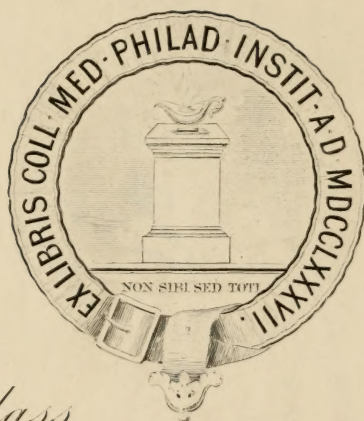




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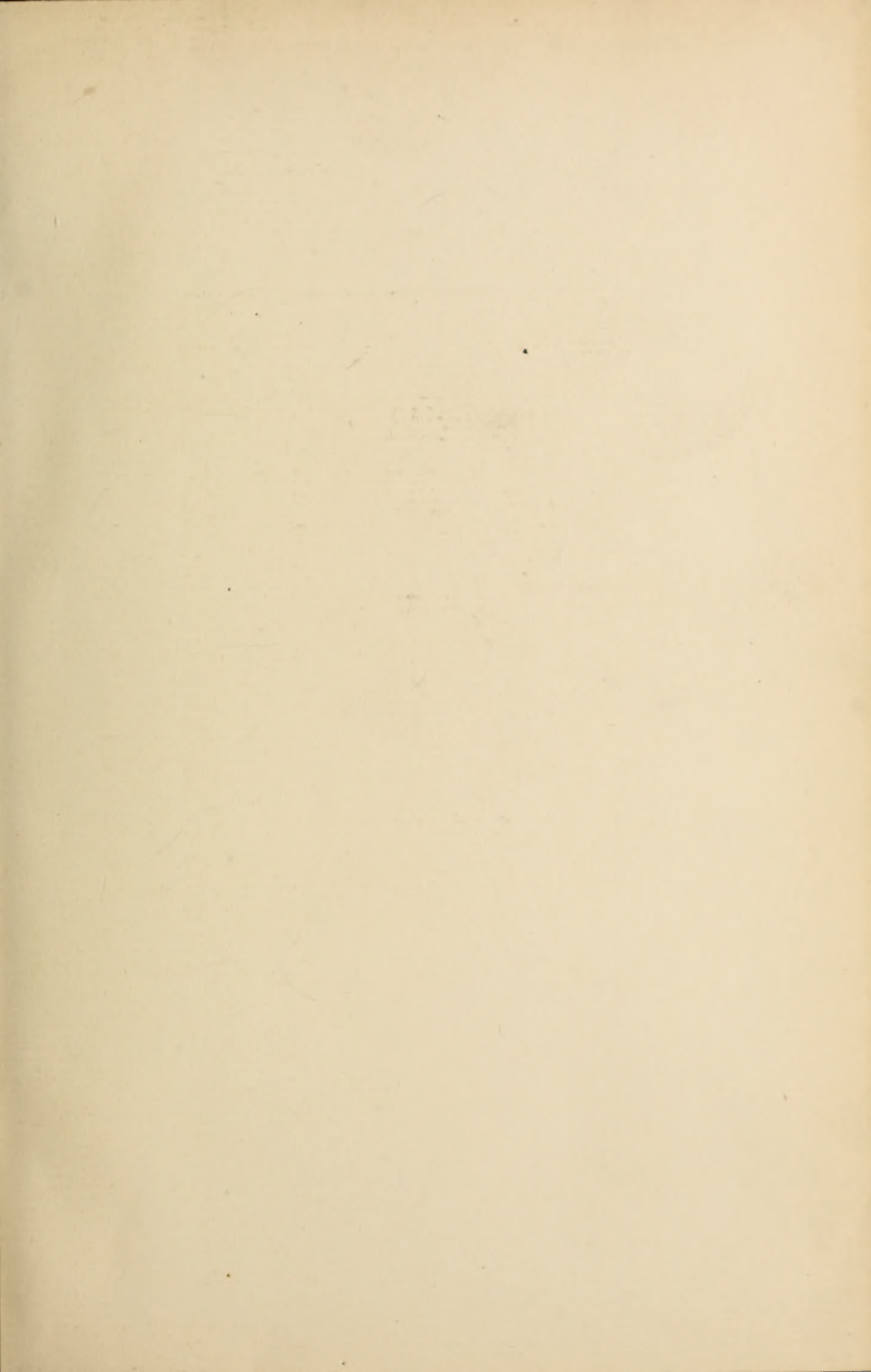



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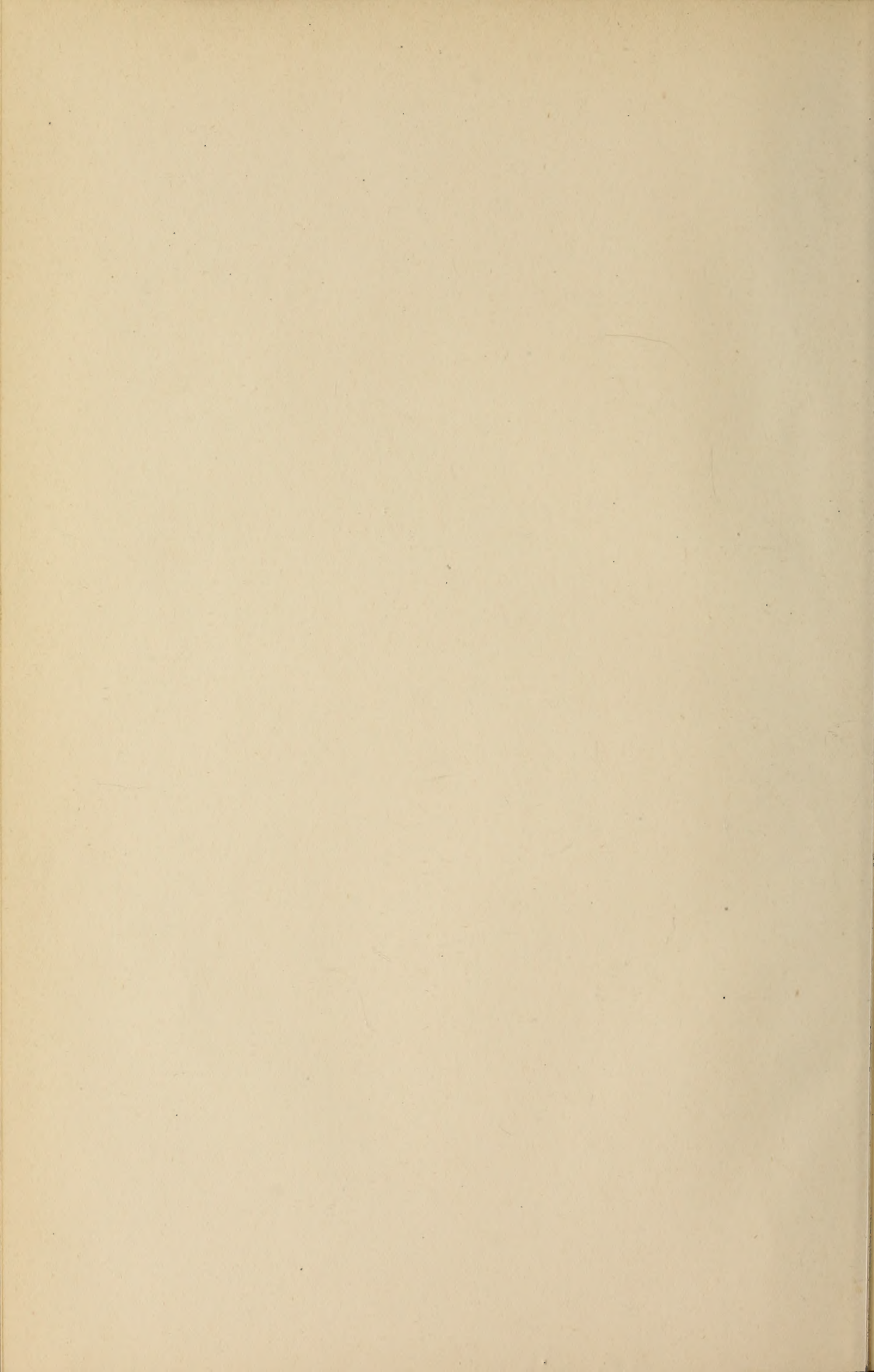
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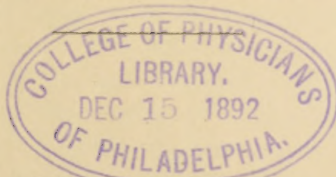
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RELIABILITY IN MATERIA MEDICA.

BY J. P. DAKE, A.M., M.D.

(Read before the Southern Homœopathic Medical Association, Nashville, Tenn., Nov., 1891.)

WHATEVER importance may attach to the scope and extent, the arrangement and convenience, of the materia medica, intended to serve as a guide for the practitioner of medicine, there is one quality of yet greater moment, indeed of supreme importance, and that is, the genuineness of what are presented as drug-effects. The materia medica of the Old School, composed largely of what are called the effect of drugs upon sick people, curative symptoms, is beset with great difficulties. The inconstant and ever-varying, not to say inscrutable, workings of morbid causes in the sick, must ever complicate and render unreliable the apparent effects of drugs administered. Since Pereira began to ascribe importance to the physiological effects of medicinal agents, and his successors to incorporate more and more of the information supplied by the Hahnemannian provings of drugs upon the healthy in their works upon materia medica, there has been a sensible improvement in their reliability. The outlook for them is more hopeful. On the present occasion, however, it is my purpose to consider briefly the situation in our own literature.

Hahnemann rightly apprehended the importance of learning the

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positive or pathogenetic effects of each medicine, as distinguished from the relative or curative; and he proposed the only possible way of obtaining the desired information—that of testing all upon persons in health. While he indicated the way in general and entered upon it himself, and with a few followers, and while he pointed out, most clearly, the sources of uncertainty and contamination likely to be opened in an effort to note drug symptoms in the sick, he afterward failed to exercise the care necessary to a pure pathogenesis. The volumes of his *Chronic Diseases* exhibit a lamentable admixture of positive drug-symptoms with those colored and vitiated by various morbid causes.

And, some of his followers have fallen into the same unfortunate habit of taking symptoms supposed to be produced in the sick by doses administered to cure, and symptoms supposed to be removed by the same, as undoubted drug-effects. Among such, not a few have been noted and widely published to the world as “key-notes,” and “guiding symptoms.”

However a symptomatology, thus composed, may be arranged for convenience of reference, it can never bear the stamp of reliability, and must ever prove misleading and unsatisfactory to the practitioner. The more earnestly it is studied, and faithfully applied in practice, the worse for the sick who are practiced upon.

But the reliability of pathogenesis has not suffered alone from such causes. Some drug-provers have undertaken to note symptoms produced by doses in which there was no probability, hardly a possibility, of the least drug influence; and some have passed by a great number of articles, having promise of medicinal power and usefulness, to prove some that are eminently disgusting as well as useless. Our old *materia medica* is, to-day, cumbered with too many provings of such substances.

But the most serious trouble has come from the defective methods adopted in the proving of drugs of unquestioned power. The failures and disappointments of physicians in the use of remedies, having a great display of symptoms in the *materia medica*, have not all come from a lack of study nor of a pains-taking application. Too often they have been due to a reliance upon symptoms that were not drug effects at all.

Where the prover was a healthy person, his occupation or environment may have so impressed him as to make his symptoms very different from those experienced from the same drug by the generality of people; or, the observation or notation of his symptoms may have

presented them as they would never appear again in the same prover, or any number of other provers, testing the same agent.

Again, where the provers of a given drug have been scattered in various localities, the means employed for the observation of drug-effects, and the methods of notation, may have been so different as to show no uniformity or congruity among symptoms which were really identical. Beside the difficulties now briefly referred to, there are others which I cannot now mention, for which I must refer you to what I have written upon the subject, in various papers for the American Institute, during the past third of a century. Holding such opinions of the ways and means of drug-proving, as followed too much from the time of Hahnemann down to the present hour, it may seem strange to you that I should be found seconding the herculean labors of Dr. Richard Hughes in the production of the *Cyclopædia of Drug Pathogenesis*, now just completed. I must explain that, after many vain efforts to arouse the profession to a sense of the deficiency in the current works on materia medica, and to the necessity of a reproof of our remedies under conditions and in ways to ensure greater reliability, I looked upon it as my duty to do all I could to have our existing drug-symptomatology subjected to a critical examination and sifting, and to have the most reliable part of the provings brought together in the narrative form, ready for the student, the compiler of manuals, and the practitioner.

I do not hesitate to say, that the *Cyclopædia* referred to presents our provings in the clearest and most reliable form at present possible.

Since its preparation was ordered by the American Institute and the British Homœopathic Society, and even before its completion, I am happy to say, the signs of a new and far better day for our materia medica have begun to appear. Earnest men in Baltimore, Boston, and New York, have begun to organize for the proving of drugs, in ways and with means calculated to eliminate many sources of error and uncertainty. I hail the opening day with peculiar pleasure, and rejoice that my life has been prolonged to behold its coming.

Long ago, I said that drug provers should be male and female students of medicine, gathered under expert supervision, and supplied with the diagnostic means considered useful and necessary in the examination of cases of disease.

I trust the work begun at our schools, in the cities named, will be taken up in every one of our colleges, so as to furnish us before the close of this century with a materia medica justly entitled to the qualifying term *pura*.

THE MATERIA MEDICA NOT WEAKENED BY REVISION.

BY O. EDWARD JANNEY, M.D., BALTIMORE.

(Read before the Maryland State Homœopathic Medical Society, Baltimore, October 6, 1891.)

A CRITICISM has been made upon materia medica revision that the important and distinguishing symptoms, those known as "characteristics," would be eliminated, and the materia medica thereby "emasculated." By the method of revision which retains only those symptoms which occur in two or more provers, it may be that some so-called "characteristics" will be omitted for the present. This can occur in but two ways; either the particular symptom has occurred in the experience of but one prover, and therefore lacks verification, or else the symptom originated in a proving so unreliable as to be unworthy of trust, and has, on this account, been omitted.

It is very true, that if the revised materia medica should contain none, or very few, of the symptoms which serve to distinguish one drug from another, each drug would lose its individuality.

This is, however, a theoretical objection; what are the facts? Have the drugs that have been revised lost their distinguishing features? Let us briefly examine some of the work that has been completed, and see how it bears scrutiny on this point.

Turn to *bryonia*, the revision of which may be found in the *HAHNEMANNIAN MONTHLY* for June, 1889. The well-known headache of *bryonia*, felt in the occipital region, and also in the forehead, is brought out in the revision.

Searching further, we find epistaxis. Thirst is prominent, although the peculiarity of demanding large amounts of water is not mentioned.

The feeling as of a stone lying in the stomach is found.

The constipation and diarrhœa peculiar to *bryonia* are included; also, the dry, teasing cough; the oppression of the chest; the stitching pains in the sides of the thorax, increased by inspiration or other movement; shooting and stitching pains in various muscles and joints, aggravated by movement. These comprise most of the well-known symptoms of *bryonia*. The weakest point seems to be the absence of fever symptoms, but these would doubtless be brought out in a proper re-proving of the drug.

Turn now to the synthesis of *gelsemium* (*H. M.*, September, 1889). We find the familiar loss of muscular power, even to paralysis;

excessive prostration, with restlessness; stupid feeling, with incapability for mental application; unconsciousness; vertigo, with imperfection of vision, amounting even to loss of sight; various forms of headache; diplopia; glimmering appearances before the eyes; yellow "bilious" diarrhœa; slow pulse; chilliness, followed by general heat, succeeded by profuse sweat with languor.

Not much is missing to complete the picture of gelsemium; the characteristics are here in force.

Take the revision of apis (H. M., June, 1890). Now what are the characteristics of apis? An irritable restlessness; general sore or bruised feeling, with sensation of heat; mental agitation, with irritable humor; swelling of various parts, especially about the eyes, with pricking and itching feeling; hot, flushed face; sensation of constriction in the throat; diarrhœa, with copious, yellow, and watery stools; scanty urine, with urging and burning in the urethra during micturition; itching, stinging, burning sensations in various localities, sometimes accompanied with numbness; swelling of the feet; irritation of the skin, consisting of itching, stinging, prickling sensation of heat, and an eruption like "nettle-rash;" and lastly, rigors, flushes of heat and fever.

Are not these the peculiar symptoms of apis? Well, every one of them is retained in the revised version. In this drug we miss scarcely one of the characteristics we have been accustomed to ascribe to apis.

Let me now call your attention to the revised symptomatology of kali bichromicum (H. M., February, 1891). Here may be found many symptoms indicating inflammation of mucous membranes, particularly those lining the nasal cavities and other air-passages, progressing even to ulceration, with the production of tough dark or yellow phlegm. Cough, with scraping in the larynx, hoarseness, dyspnoea and expectoration of tough mucus is also found. The peculiar action of kali bichromicum in causing boils and ulcers on the skin and mucous membrane is well brought out.

Here again, it is clearly seen that the characteristics of the drug are not lost, but, on the other hand, owing to the numerals which are attached to each symptom, the characteristics which really belong to the drug are brought out into greater prominence. This is well shown with kali bichromicum in another way. Perhaps, not a great many physicians make use of this remedy in rheumatism. Well, a study of the revised symptomatology brings this feature or power of the drug into so strong a light that any one may see it. Of the forty-

two provers of kali bichromicum, more than one-third experienced pains of a rheumatic character, and its value as a remedy for rhematism is worthy of remembrance.

A further illustration of this point may be seen by a glance at the skin symptoms, where a most excellent picture of small-pox is presented, in which disease this remedy would doubtless give good results.

The revision of *coccus cacti* has but recently been completed. This drug is an excellent one to test the value of the adopted method of revision, since practically there is but one group of symptoms which *coccus cacti* cures, although it may occasionally be demanded in others. This one group of symptoms in the symptomatology of *coccus cacti* is that which bears a close resemblance to the paroxysm of whooping-cough. If, therefore, this group of symptoms is lost in the process of revision, the method, at least so far as this drug is concerned, is a failure.

Let us see how the drug stands this test. According to the symptomatology of *coccus cacti*, as arranged by the Medical Investigation Club, the symptoms comprising the section "Respiratory Organs" are as follows, the whole number of provers being 19:

Irritation in the larynx, which causes coughing.⁶

Hoarseness.⁹

Irritation in the trachea.⁵

Painful sensations in the lungs.³

Cough.¹² Cough caused by persistent irritation in the bronchii.² The cough is short;⁵ dry;⁶ frequent;⁵ "in short fits;"⁴ disturbing sleep at night;³ with a tendency to produce vomiting.²

Expectoration.⁸ Expectoration easy and in large amount;² viscid and clinging;² yellow in color;³ in grayish lumps.²

Dyspnœa.³

Out of this rubric a fairly correct description of whooping-cough might be constructed. To be sure, there does not appear in so many words that symptom of *coccus cacti* which appears so absurd on first sight, "expectoration, which may be drawn in strings to the feet," but if the phlegm is "viscid and clinging," as appears in the above symptomatology, it probably may be drawn into long strings on attempting to clear it out of the mouth.

It is clear, therefore, that the chief characteristics of *coccus cacti* are not eliminated in the revising process. The method of revision then, in so far as this drug is concerned, is above criticism.

The drug aconite is characterized chiefly by great restlessness and mental excitement; anxiety and apprehension; neuralgic pains; cough, with difficulty of breathing, and expectoration of bright red blood or blood-streaked mucus; and by the symptoms of fever. These symptoms may all be found in the revised pathogenesis of aconite (See HAHNEMANNIAN MONTHLY, June, 1891).

For a drug which is in such constant requisition as aconite, a remedy which originated with Hahnemann, to whom should be given the entire credit for its introduction into medicine, and the chief use of which is the relief of febrile conditions, it would seem that the fever symptoms, as brought out by the standard works on materia medica, are quite insufficient to point out its value as a fever remedy.

So true is this, that it is safe to say if the present works on materia medica, which contain the symptoms of drugs in schematic form, should be placed in the hands of any student just beginning the study of materia medica, and he should be told to select the remedies therein contained which would probably prove useful in fever, aconite would not be one of those selected.

Hering mentions but two symptoms relative to fever:

"With the chill, internal heat, anxiety, red cheeks, body chilly, hot forehead and ears, internal heat. Dry heat, with thirst, short breathing, etc."

Cowperthwaite, in his *Materia Medica*, copies these two symptoms.

In Allen's *Handbook* these two symptoms are again found. In addition, heat is mentioned a number of times with variations, as dry heat, internal heat, heat all over, flushing heat; and described as occurring in the head, face and other localities. No reference is made to the use of the clinical thermometer, and there is no indication in any of these works as to whether any one symptom occurred often in the provings—all appear as of equal importance and of equal insignificance.

Place now by the side of the above, the section on Chill, Fever and Sweat, as revised, especial attention being called to the fever symptoms (HAHNEMANNIAN MONTHLY, 1891, p. 357). Number of provers of aconite, 38.

Coldness.¹⁴ Chilliness,¹⁴ especially towards evening.⁴

Chill followed by dry heat;¹³ and sweat.⁵

Chill and heat alternating.⁵

General increase of heat;²³ especially in the head² and face;⁸ with thirst;² followed by sweat.⁶

Increased temperature, as shown by the thermometer.³
Copious perspiration ;¹¹ following chill.³

It would seem, then, that the criticism which has been made upon the work of revision is not borne out by the facts. The "characteristics" are nearly all retained, and in fact our materia medica, instead of being "emasculated" by the revision, has been thereby greatly strengthened.

SOME PRACTICAL OBSERVATIONS CONCERNING EXAMINATIONS OF THE HEART.

BY E. R. SNADER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

It is certainly true that a mere theoretical knowledge of the morbid conditions that may affect the cardiac apparatus is insufficient for diagnostic purposes. Even a knowledge of the physiological cycle of the labor performed by the heart, while an absolute essential to the correct understanding of the morbid alterations liable to occur in the central circulatory organ, is not sufficient to insure a correct diagnosis of an abnormal condition. An understanding of the normal workings and evolutions of the heart, as well as a theoretical knowledge of the morbid conditions incident to diseases of that organ, must be supplemented by a practical knowledge—a working knowledge, a comprehensive knowledge, a discriminating knowledge—in other words, the phenomena discovered must be weighed by a correctly-balanced judgment and an exquisitely poised power of discrimination.

The text-books attempt to lay down, rather dogmatically it seems to me, iron-clad laws for diagnosis. Even he who reads between the lines, and attempts to gain a comprehensive grasp of the steps necessary to arrive at a correct solution of a problem in cardiac diagnosis, is struck, on the one hand, with the positiveness of assertion regarding the diagnostic criteria available in certain lesions, and on the other, by the vagueness and uncertainty of groups of symptoms and physical signs present during life, and the definiteness of the lesions discernible after death.

It seems to me, that in order to investigate the heart properly,

for morbid conditions, it must be regarded from at least two stand-points: First, as a pump, acting on strictly mechanical principles; and second, as a vital organ. As a pump, the heart is subject to the laws of mechanics, and alterations in the physical conditions under which it works are reflected directly upon the cardiac structure. It is a central organ, and the larger and peripheral avenues for the course of the propelled current of blood must be regarded as essential parts of the blood-propelling apparatus. In other words the heart itself must not alone be considered; the arteries and the veins, must be taken into account as essential parts of the circulating mechanism, and, in some instances, the organs and tissues through which the arterial tide flows, must be investigated for causes interfering with its work and action of the heart.

As a vital organ, the heart may be acting abnormally independently of any known disease. As a vital organ, too, the heart dominates the pump; and, however perfect, as a piece of mechanism the heart's propelling power, it may be affected by the action of the heart as a vital organ. As a vital organ, the heart can be disturbed by many trivial, as well as by grave tissue alterations, the result of local or general disease; it may be disturbed by systemic states, not actually normal, to which we have not, as yet, been able to give a definite and distinctive name; it may be disturbed by the influence of the will, by psychical states, by emotions, by exertion, by temperature alterations, and by many other factors. The heart, then, is a pump, dominated by its intrinsic nature as a vital organ, and, as a vital organ, is subject to various influences outside itself, as well as to disorders peculiar to its own structure. The heart is a heart, but it is also a part of a systemic whole. The specialism that fails to recognize an organ in its relations to the whole man, as a psychical as well as mechanical creation, is unworthy the name.

Viewing the heart, then, from the stand-points of a pump and of a vital organ, we examine the organ; first, as to the condition of its walls; second, as to the condition of its cavities; third, as to the condition of its orifices and valves; fourth, as to its condition as a vital organ, and fifth, as to its relation to the system at large.

It is not the intention of this paper to systematically treat of the rules and methods of procedure in cardiac diagnostics; that would simply be a recapitulation of standard knowledge, and would transcend the scope of my paper. I simply want to point out some manifest misstatements of the text-books, and, in a desultory way, present some observations that may be of service to you in examin-

ing hearts, and to insist that practical experience alone can determine the value of diagnostic criteria, and to protest against the application of arbitrary and acoustic laws to the solution of questions in cardiac diagnostics.

Valvular Lesions.—The text-books point out certain regions in which you must hear heart-murmurs originating at certain orifices. For instance, the diagnostic features of mitral regurgitation are given briefly as follows: A murmur heard with the systole, having its maximum of intensity at or near the apex, and transmitted laterally around the left side of the chest, and often heard on the posterior aspect of the chest near the lower angle of the left scapula. In point of fact, mitral regurgitation exists without any such localization of intensity or line of transmission. I have heard a murmur of mitral origin three inches below the left nipple, possessing at this point its maximum of intensity, the first sound in the mitral area being simply blurred. I have found murmurs, also of mitral origin, an inch from the sternum, and also midway between the apex and base of the heart, and also two inches outside the left nipple. I have frequently found murmurs originating at the mitral orifice best transmitted to the apex of the left lung, two inches below the clavicle, when there was a feeble or no lateral transmission. In fact, I have been led to investigate the heart for disease by discovering such a murmur while examining the respiratory organs. This transmission has occurred when the left lung was solidified and when it was not. I have heard mitral murmurs that were transmitted all over both chests.

The diagnostic evidence of the mitral origin of these anomalous (?) murmurs was an impairment of the mitral valvular element of the first sound, the normality of the tricuspid valvular first sound, the accentuation of the pulmonary second sound, together with a predominating hypertrophy of the right ventricle. If it were accepted as an arbitrary fact that a murmur originating at the mitral orifice must have its maximum of intensity at or near the apex beat and a certain definite line of transmission, such murmurs as I have described would have remained undiscovered or wrongly attributed to lesions occurring at other cardiac openings.

The difficulties experienced by some practitioners in discovering valvular lesions arises from several causes. Aside from a too close adherence to text-book facts, the principal reasons for failure are, I believe, a misapprehension of the nature of the signs indicating valvular lesions, a preconception of the character of the sound or sounds

they are searching for, and the mental retention of an ideal murmur to which all sounds are compared, a lack of practice, and an uneducated ear. A murmur is a new sound, preceding, following, adding to, or replacing the normal cardiac sounds. A murmur varies greatly in its sound characters. If the last sentence be fully appreciated, and a murmur is understood to be a new, an added, an abnormal sound element, a proper conception will be had of the nature of murmurs. No two murmurs are precisely alike in all respects, and you can see that if a practitioner compares a sound he is studying with the characters of a sound he has heard in another patient, he will of necessity be dominated by a false standard. The ear can readily be educated to appreciate the slightest modifications in the cardiac sounds and intervals. It is a mistake, at least for those who have but little practice in cardiac diagnosis, to fail to review the case after the diagnosis has once been made. It was formerly my habit, after having made an elaborate diagnosis, to study repeatedly, at every visit, the heart, as if I did not know what was wrong. In other words, I learned every twist and turn of the heart, and soon became able to note the slightest modification in the intensity, pitch or quality of the murmur, and also the changes taking place in apparently unaffected cardiac sounds. Others, I am sure, can acquire equal skill. I learned in this way that the dictum of the text-books, that organic murmurs do not change in intensity, was untrue. Murmurs vary in intensity according to the activity of the heart, and according to the force of the systole.

It is quite possible that a peculiar arrangement of the obstruction of the orifice or irregularity of the valves, for acoustic reasons, may have much to do with the intensity of a murmur, but I am confident that the force with which the blood is propelled against the obstacle is a factor of infinitely greater prominence than the mere position of the lesion. Indeed, I look with much suspicion, prognostically, on a murmur that diminishes in intensity under my observation. The inference I draw from such a decrease is that rupture of the compensating hypertrophy has occurred, and ventricular dilatation is ensuing. I have known of murmurs that could be heard readily at any part on the chest. Not only the so-called characteristic transmissions were present, but as I have just said, the abnormal sounds could be heard anywhere over the thorax. I have known these same murmurs to become so diminished in intensity as to be scarcely audible, and while, had I seen such cases for the first time, I would have been able to diagnose dilation of the ventricles, it is

questionable whether I should have been certain of determining that the dilatations were sequential to valvular disease. You can see now why some murmurs are not transmitted characteristically, and also why concomitant evidence is quite as valuable in diagnosing valvular lesions as the presence of murmurs. A poorly transmitted murmur, weak in intensity, is more difficult to recognize than the characteristic ones, but the recognition of the slight ones is of far more importance, both in a prognostic and therapeutic sense, than the murmurs so readily appreciable, and of which the text-books tell you.

Palpitation of the heart will increase the intensity of a previously-present murmur greatly, but still slighter causes, sometimes appreciable and sometimes not, will cause the same change. I have learned, too, that a murmur occurring during palpitation of the heart is not of necessity organic in origin, but that it is organic in nine cases out of ten under these circumstances, the violence of action simply bringing the valvular deficiency into prominence. If the heart sounds be blurred during intervals of freedom from palpitation, either systolic or diastolic asynchronism exists, or there is a valvular lesion.

I have learned that an aortic stenotic murmur can be transmitted downward with greater intensity than upward, and is even, in some cases, not transmitted at all into the carotids. The diagnostic evidence in such cases was complete as to the character of the lesion. I recall the data in one instance: A murmur heard constantly over the aortic area, with the systole, the sound being notably impaired, the second decidedly accentuated, with a decided hypertrophy of the left ventricle, with inconstant systolic murmurs heard over the tricuspid and mitral areas.

There are several possible sources of error in searching for cardiac murmurs upon which I desire to lay special stress. When the ear is imperfectly approximated to the chest over the apex region, the impulse frequently makes a consonating chamber of the auditory canal and external ear, and simulates a murmur very closely. It is differentiated from a real murmur by its closeness to the ear and its disappearance when the ear is firmly pressed to the naked chest, thus excluding all sound save that coming from within the thorax, and also by the use of the stethoscope. The boom of an hypertrophied heart, by reason of its so-called tinnitus, is also liable to be mistaken for a genuine murmur. This sound is differentiated from a sign indicating a valvular lesion by the fact that the valvular element of the systolic sound (the only sound producing this sort of tinnitus) is normal, and simply presents the modifications incident to the hyper-

trophy. The rubbing of the clothing upon the chest can simulate a murmur. A lack of synchronism with the cardiac sounds or their intervals differentiates this apparently abnormal sound, and the removal of the clothing settles the point beyond peradventure. Wax in the examining ear is very often, indeed, a source of error. Nearness to the ear differentiates this sound from one indicative of serious lesions. I have made repeated examinations with quite a collection of wax in the ear, and have simply made allowance for the sound-elements produced by the wax, and have been led into no errors in diagnosis, for I have by subsequent examinations, when my ear was free from wax, confirmed my first finding. Another source of error is a distinct murmur that occurs in my own ear, at times, after much stooping, exertion, or drinking water. With every systole I could hear in my own ear, whether examining or not, and especially if there was absolute quiet, a distinct murmur. I learned to make successful examinations even during the temporary presence of this murmur. I shall not waste time in an attempt to explain the mechanism of this sound. Suffice it to say I differentiate it from a murmur I hear in a patient, if I do hear one, by its being directly in the ear, and by the fact that it is synchronous with my radial pulse and asynchronous with the pulse of the subject of examination. If the patient's pulse agrees with mine, I have him exercise until I run the pulse up ten or twenty beats more than my own. I have, in these cases, too, made subsequent examinations and compared the results of my first observations. The respiratory sounds not infrequently are sources of error. They can be usually made to disappear by suspending the respiratory acts. A still graver source of error, also connected with the sounds originating in the lungs, occurs when the lung overlaps the mitral area, and the impulse of the heart with each stroke drives the air forcibly through the air cells impinged against the chest-wall, producing with each impulse an apparent systolic murmur. Great care is sometimes requisite to avoid mistaking this systolic sound for a murmur, indicating either mitral regurgitation or an mitral intra-ventricular lesion. I employ several measures to determine whether the murmur originating as I have described really has its source in the mitral area or not, and by careful attention to concomitant evidence it is always possible to determine the murmur's exact origin, and even to make out with positiveness the coexistence of an organic murmur with a lung murmur, as I term the sound under consideration. If the mitral valvular element of the first sound retains its normal purity,

I am sure that the murmur heard originates as I have described, and that the mitral valve is normal. This lung murmur, inasmuch as the quantity of air varies relatively during several beats of the heart, even although the sounds are apparently synchronous with the systole, fluctuate in intensity, are irregular as to length, and betray the breezy quality of the respiratory murmur. By suspending respiration, and examining during both forced inspiration and forced expiration, I am enabled to study ultimately the cardiac sounds, and determine upon their normality or abnormality. I sometimes put the patient on the left side and then secure a forced and held respiration, until the vocal resonance has disappeared from the mitral area, and I then study the signs originating at the mitral orifice. I sometimes study the sounds originating at the tricuspid orifice, and then, my ear still being in the tricuspid area, carefully study the mitral sounds, and make comparisons undisturbed by the long murmur. I find a stethoscope a useful instrument in these differentiations, yet I must say that there is a possible source of error attached to its use.

It appears to be a general belief that if a murmur is not discoverable by a stethoscope, no murmur exists. It is made, apparently, an instrument of precision and decision. This is a mistake. I have found murmurs with the naked ear that I did not find with the stethoscope. The naked ear takes in sounds from a larger area, and is therefore of greater value in finding abnormalities. The stethoscope intensifies sound, and should be used as a check. Neither the ear nor the stethoscope should be used to the exclusion of the other. Perhaps the one reason why the ear discovers murmurs not heard with the stethoscope finds its explanation in the fact that when the instrument is used, the regions arbitrarily marked out in the text-books as the points at which certain murmurs are to be looked for, only are explored. As a positive fact, murmurs are frequently discovered outside the boundaries so elaborately laid out by systematic writers on physical diagnosis.

A murmur, too, is often heard without lesion, when there exists a cavity in the left lung. It is apparently due to the systolic agitation of the air in the cavity. I need not refer to the murmur so commonly found in phthisical patients—that over the pulmonary area.

There is one statement made in the text-books that is full of significance, and to which half enough attention has not been given by the vast majority of examiners. I refer to the statement that murmurs are sometimes heard in the recumbent position when they are

not audible in the standing position. Too much insistence cannot be laid upon the necessity of examining for murmurs in both the standing and recumbent positions. In the text-books the fact is stated baldly, when it should be emphasized strongly. I hold it as of cardinal importance in cardiac diagnosis, that the subject should be examined lying as well as standing. An examination is never complete without this procedure. An opinion given as to the condition of the heart from an examination when the patient is standing, is comparatively valueless as to the non-existence of valvular lesions particularly. An opinion given from an examination without these precautions, amounts simply to the negative declaration that there is no evidence of the existence of a valvular lesion while the patient is examined standing. Such an opinion is partial, incomplete, unscientific, misleading, and is positively a reflection on the diagnostic skill of the examiner. I have diagnosed lesions affecting the valvular orifices of the heart quite a number of times, when good men, who are undoubtedly able to detect changes in the cardiac sounds, have declared the heart examined normal, or, at least, have positively and decidedly declared that no valvular lesions existed. I have, myself, by failure to attend to this precaution, at least twice made the blunder of declaring the heart simply deranged functionally, when subsequent examinations, under different circumstances, betrayed well-marked murmurs, indicative of gross organic and orificial lesions. I am positive, from associated facts, and a combination of presumptive evidence, that the lesions had not arisen since my previous examinations. The simple truth is, that the lesions, well marked and unmistakable, had escaped my ear because of my failure to observe the precaution of examining the heart while the patient was in different positions before I gave my opinion as to the nature of the heart trouble. Various causes, some not well understood, contribute to make a murmur more audible, or only audible, in certain positions of the body. In one case, the boom of the systole of an hypertrophied heart—hypertrophied secondarily to a valvular lesion—was so great as to completely obscure the sound of the murmur. The lying position carried the apex away from the chest-wall, and with it the boom of the first sound, and permitted of the ready appreciation of a well-marked and unmistakable systolic murmur. It is not within the intention of this paper to attempt the further elucidation of possible causes of the failure to hear murmurs in certain positions. In making delicate comparisons of the cardiac sounds the præcordial region should always be exposed.

Keeping in mind the precautions I have endeavored to point out, and keeping also in constant view the possible sources of error, in searching for a valvular lesion, it is to be borne in mind that a murmur is an added modification of the normal heart-sounds, or a sound or sounds occurring during the intervals between the beats; a modification that has varying degrees of intensity, pitch, quality, and rhythm, in different cases. In general, it may be said that no two murmurs are exactly alike. A modification of the heart-sounds, a blurring, an impairment of their purity, should immediately suggest the possibility of a valvular or orificial lesion; and the murmur indicating the lesion should be sought for, not only in the positions pointed out in the text-books, but everywhere within the præcordial region, and even three or four inches outside that area. By such a systematic search you will often be rewarded by the discovery of a murmur, and then, by a careful study of all the elements of the heart-sounds, will also be able, in the majority of instances, to locate the lesion at its proper valvular orifice, and determine, also, whether the murmur is organic or inorganic, and whether, if organic, it is compensated fully or not, and, whether the murmurs discovered indicate regurgitation, obstruction, or, even if organic, it be innocuous. In listening for murmurs, frequently, a slight blurring of the heart-sounds will be the only obvious change suggesting abnormality; but after a long search a murmur will sometimes strike your ear, and afterwards you can hear it without difficulty. Such a murmur, perhaps at first only audible while the patient suspends respiration, can then be distinctly recognized as specially cardiac, by reason of its peculiar sound-characters, no matter how intense the respiratory sounds may be. Slight murmurs it is almost impossible to recognize at first, owing to their not being readily heard in the respiratory murmur. A murmur heard when the sounds of respiration are suspended, should always be listened for, after recognition, while the respiratory murmur is active. If doubt exist as to whether a murmur has been heard, take the totality of all the physical signs into consideration, before deciding that a murmur is not present. In point of fact, concomitant evidence, pointing to the existence of a valvular lesion, is quite as valuable, in many instances at least, as to the existence of a valvular lesion, as a murmur itself. I have diagnosed the presence of lesions involving regurgitation at the mitral orifice without any murmur at all, and have subsequently confirmed the diagnosis. Under the administration of heart-tonics, the cardiac muscle was better able to do its work, and the murmur indicative of the lesion

has, later, become plainly evident. In one instance, the murmur again disappeared when the heart became more markedly dilated. The dictum of the text-books that absence of murmurs indicates absence of valvular or orificial lesions, is only relatively, not absolutely, true. Nor is a murmur indicative of a valvular lesion, constant, *i.e.*, always heard with every heart-sound. This is notably true where there exists reduplication of the heart-sounds. The murmur may be absent for several beats, and, when heard, is not always as exactly synchronous with the sound that concomitant evidence shows should be the sound with which the murmur should occur.

A blurred heart sound, however, does not always indicate a lesion affecting the cardiac valves or openings. It sometimes indicates a slight degree of asynchronism in the systole of the ventricles, an asynchronism not sufficiently marked to give rise to a pronounced reduplication of the heart sounds. In such cases the absence of a positive murmur, the presence of the blur with the first sounds as heard *at all* the orifices, the general feebleness of the circulation, and the discovery of some source of obstruction in front of the circulation, with other evidence, different in different cases, will assist in determining the condition causing the blurring. Generally the blurring is caused by a failure of the compensation in valvular disease, the beginning break-down of an hypertrophy unequal to the task of compensation, and is a condition requiring active therapeutic interference, or indicates the oncoming of heart failure in acute diseases.

During acute diseases of an adynamic type, a blurring, and sometimes, indeed, a positive murmur, is heard, presumably not due to the supervention of an endocarditis, inasmuch as subsequent examinations after recovery disclose no cardiac lesions. There are two possible explanations of the origin of this blurring, aside from the occurrence of the dangerous asynchronism I have just pointed out. The changed character of the blood elements may account for the modification of the systolic sounds, but a more probable explanation is that the papillary museles lack tension, in consequence of the lack of nutritive elements in the impoverished and changed blood, and the lack of tension in the museles renders possible such alterations in the valves as to cause the blurring or murmurs. This sort of blurring must be carefully discriminated from the one indicative of asynchronism. Practically, however, it is sufficient to know that all murmurs heard during acute illnesses are not of necessity due to the supervention of an endocarditis.

I want to say just here that if a valvular or orificial lesion be dis-

covered during the course of an examination, it is not always the lesion that is responsible for the symptoms of which the patient complains. It would be a serious mistake to believe that simply because a lesion was discovered, that of necessity the cardiac symptoms and cardiac irregularity were due to that lesion. In practice this error is often committed by otherwise competent men. In point of fact, I have succeeded in greatly ameliorating the condition of patients who had been treated for the results of a ruptured compensation, when in reality the compensation was perfect. A diagnosis of a valvular or orificial lesion has often been considered to be the cause of disturbances in cardiac rhythm and of special symptoms. To be quite plain, functional heart disorders and valvular lesions often coexist. It is simply folly to direct your therapeutic measures toward the restoration of a compensation that needs no restoration; or, in other language, to make the mistake in judgment of considering perfect compensation responsible for disturbances of rhythm and other cardiac phenomena. Such therapeutic measures are calculated to do more damage than good. When the heart has not failed as a cardiac pump, when the heart sounds are normal in their intensity, exclusive of the changes made by the valvular lesion, when there is neither asynchronism nor reduplication, when the long and short pauses of the cardiac revolutions preserve their normal relationship to the heart sounds, and when there is no peripheral or local evidence of impaired circulation, disturbances in rhythm, either an increase in rapidity, or slowing of the heart's action, even irregularity and intermittency, are not of necessity evidence that compensation is rupturing or ruptured, even if marked murmurs be present. The fact of the co-existence of functional with organic disease is of vital importance both therapeutically and prognostically. Symptoms and signs, therefore, referable to the heart as a vital organ, are not of necessity of value, in a diagnostic sense, as indicating a rupture of compensation in valvular disease. I make this statement in a broad, not in a restricted sense. Be careful, then, not to consider that all cardiac symptoms are due to a valvular lesion, if you discover it. A very little practice indeed will furnish the necessary data for discrimination in these double cases.

Another error frequently made by the general practitioner is a failure to examine into the condition of the heart as a vital organ during acute illnesses. Perhaps a first examination is made, and no gross organic disease being discovered, the heart is thereafter neglected, or the radial pulse is carelessly interrogated. The radial pulse

is by no means a criterion of the condition of the heart as a vital organ. Your findings at the wrist are simply suggestive. The radials are subjected to the variations of arterial tension, and an examination may give you a fair idea of the condition of the arterio-capillary system, of the condition of the coats of the artery, of the condition of tension, but most certainly not of the actual condition of the heart itself. The radials may be full and yet the heart be failing. The pulse furnishes corroborative evidence. Cardiac failure in acute diseases could often readily be averted if the first changes in the cardiac sounds were noted, and the significance of their modifications understood.

In examining to determine the size of the cavities of the heart, if you expect to make fine distinctions you will be greatly mistaken. Many of the delicate text-book hypertrophies and dilations are only discoverable post-mortem, and are practically not diagnosable during life. It is within our province to determine the existence of hypertrophy, of dilation, or a preponderance of either, of valvular lesions, and sometimes of fatty degeneration and myocarditis, and also to determine, in most instances, the vital vigor of the ventricular walls, *i.e.*, the strength of the heart as a muscle, and its capability of performing its work as a pump. The signs of enlargement are easily obtainable. The differentiation between hypertrophy and dilation is made largely from factors furnished by the character of the cardiac sounds and the force of the impulse. Where no impulse is detectable by inspection from in front or side, I have sometimes been able to locate the seat of the apex beat by looking from below upward. In determining the force of the impact of the heart against the chest-walls, after failure by the usual methods of palpation, I have placed the patient in a knee-chest position, and have made my observations with the stethoscope. I have succeeded in some instances by placing the patient well on the left side, this position naturally displacing the apex beat outward, and have thus been enabled to judge of the force of the heart's impact. The force with which the heart strikes the chest-walls is of importance in determining the state of the heart as a muscle. Concomitant evidence of weakness must also be furnished by other signs.

It must be remembered that grave dilatation of the heart can exist when a considerable muscular element is noticeable in the systolic sounds. Frequent previous examinations are of extreme value in determining the real weakness of the heart. Where I have been in the habit of making frequent examinations in individual cases, I have been enabled to detect serious dilation, although the heart

sounds, compared with another individual's, might apparently be indicative of a fairly compensated hypertrophy, or of good muscular power in the organ. Even in first examinations, by carefully noting the manner in which the heart acts, and the concomitant evidence offered by changes in the second sounds of the heart, the alterations in the intervals, together with symptoms indicating cardiac failure, save in very exceptional cases, there is little difficulty in determining the exact state of the heart. I have noticed this apparently considerable amount of the muscular element in the first sound, especially in hypertrophies, with dilations, secondary to such lung lesions as emphysema and fibroid phthisis.

Another point to which I wish to call attention is cardiac pain. The impression left by the perusal of the text-books is that pain is almost totally absent in organic heart disease. So universal is this belief that the conclusion is drawn that the presence of pain (excluding, of course, angina pectoris, which may or may not be associated with detectable organic disease) argues in favor of a disease being functional in character. Indeed, some physicians use this supposed fact as possessing diagnostic value in differentiating between organic disease and inorganic disease. I must protest against the further propagation of this error. Organic heart disease does cause decided pain, not anginal in character, in so large a number of cases, that the particular assertion of the text-books is rendered valueless. At least so my experience speaks. While not very frequent, pain is often enough complained of in cases of organic disease, to render the diagnostic conclusions drawn from the presence or absence of pain valueless. I have been careful, in the organic cases characterized by pain that have come under my observation, to eliminate pleurodynia, intercostal neuralgia, myalgia, gaseous distension of the cardiac end of the stomach, and other possible sources of error.

ENCYSTED VESICAL CALCULUS.

BY CARL V. VISCHER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

THE object in presenting this report is two-fold. First, to point out the importance of making a careful physical examination, even

in those cases where the subjective symptoms seem trivial, and secondly, to briefly consider a subject which, judging from the current literature, is not of frequent occurrence.

Mr. W. S., æt. 35, had always enjoyed good health until some twelve years ago, since which time he had been suffering, on and off, from dysuria, which frequently became greatly aggravated, the pains shooting from the rectum through the perineum to the glans penis; ordinarily, however, he experienced but comparatively little pain, save at the end of micturition, at which time it became quite acute, especially in the glans. His principal trouble, however, that which annoyed him most and for which he sought relief, was his urine. This was exceedingly cloudy, on standing depositing large quantities of mucus, and was of an extremely strong odor. On questioning, it was learned that on one or two occasions he passed some blood with his urine; in other respects his history was negative. An examination of the urine showed it to contain a large amount of pus, great numbers of triple phosphates, bladder-cells, and some albumin—the latter, however, could be accounted for by the former; there were no kidney elements found. The history certainly spoke for prostatic trouble, and the urinalysis for the presence of a cystitis, for which he had been treated more or less constantly with but temporary relief. As neither of these conditions are likely to be idiopathic, and the most frequent cause of them being denied, without a careful physical examination one would certainly have been at a loss to account for the symptoms. This being done, however, the cause was readily explained. A finger introduced into the rectum found the prostate normal; about a finger's breadth above this, and to the right, a tumor was detected on the posterior wall of the bladder, extending beyond the reach of the finger, of almost a stony hardness. The bladder having been filled with some eight ounces of Thiersch's solution, a Thompson's sound was introduced, revealing slight trabeculation, otherwise nothing could be detected until the water was allowed to flow out, at the same time making the usual manipulations with the searcher; as the bladder emptied itself and became contracted, a tumor, corresponding to the one detected by the rectal examination, was found, the surface of which was perfectly smooth and very hard, but giving no click; a tumor of such a character being almost unheard of in the bladder, a sacculated stone was suspected, and on introducing a finger into the rectum with the sound in the bladder, the presence of a calculus could be quite readily made out, by making alternate pressure with the finger and sound;

the stone being some little smaller than the cyst in which it lay, it could be moved from one side to the other. Feeling confident of the diagnosis, supra-pubic cystotomy was advised; the other methods for the removal of stone were excluded for obvious reasons. After due consideration on the part of patient and friends, operation was consented to; and accordingly, with the kind assistance of my friend, Dr. Congosto, the bladder was opened in the usual way, excepting that a finger introduced into the rectum took the place of Peterson's bag.

The patient having been placed in Trendelenburg's position, viz., elevated pelvis, on opening the bladder, the tumor was pushed upward and forward, when the tissue covering the stone, which apparently was inflammatory in origin, was incised, and after some difficulty the stone, which was of no mean size, and composed of uric acid nucleus with a phosphatic covering, was delivered—the difficulty arising in that the calculus was firmly imbedded in its long axis. After thorough irrigation, a Dittel modification of Trendelenburg's drain was introduced, and the abdominal walls partially united by the introduction of two stitches. The wound was dressed with iodoform gauze. The patient made a rapid recovery, the highest temperature being $100\frac{2}{5}^{\circ}$ on the day following the operation.

The literature on the subject seems very meagre. In the operated cases reported, the stones were either in diverticulæ or not completely encysted. Fenwick mentions one in which a large calculus was partially encysted, and so adherent to the mucous membrane that it was necessary to remove it by means of a mallet and chisel. Other instances of encysted or rather sacculated stone are reported, where the calculi were of small size and several in number. One or two cases of completely encysted stone reported, were only found post-mortem. Pathologically, but little is known, save that diverticulæ are comparatively rarely found congenital, when they not infrequently, for obvious reasons, are the direct cause of stone formation. The sacculations in which calculi are more often found are secondary to the development of the stone, the weight of which forces the mucous and sub-mucous coats of the bladder between the muscular fasciculæ, in that respect differing from the true or congenital diverticulæ, as they are made up of the layers of the bladder. In the case just cited, there apparently was a congenital diverticulum, or an exaggerated cæcal or retro-prostatic pouch, which, owing to the irritation of the stone, gave rise to a plastic inflammation, which resulted in the complete encysting of the calculus.

BIBLIOGRAPHY.

- Remington, "Medical and Chirurgical Transactions," 1886.
 Fenwick, London "Lancet," 1888.
 Harrison, *Ibid.*, 1884.
 Lediard, *Ibid.*, 1879.
 Morgan, *Ibid.*, 1887.
 Mellock, "Medical News," Philadelphia, 1885.
 Clarke, "Medical News," London, 1888.
 Oliver, "Transactions Texas Medical Association," 1887.
 McBurney, "New York Medical Journal," 1888.
 Browne, G. B., "British Medical Journal," 1888.
 Browne, B., "Medical Press and Circular," London, 1890.
 Johnson, "Virginia Medical Monthly," 1889-90.
 Mardle, "Dublin Journal Medical Sciences," 1890.

CIRCUMCISION.

BY H. EVERITT RUSSELL, M.D., NEW YORK CITY.

THERE is a strong tendency on the part of some physicians to advise the indiscriminate circumcision of all male children, not, like the Jews, upon religious grounds, but as a matter of cleanliness, etc. Now, in cases of phimosis, encuresis and some other ailments, there is no doubt that circumcision is a perfectly justifiable surgical operation, but like any other surgical operation it is, in the opinion of the writer, entirely *unjustifiable* to thus mutilate a child that is perfectly sound. No good reason for circumcising every boy-baby has ever been given, and it is doubtful if any excuse could be suggested for such interference.

Dismissing the religious theory as not requiring consideration—except from a legal standpoint, to which reference will be made further on—there seem to be but three reasons brought forward by the advocates of indiscriminate circumcision: (1) cleanliness (2) that the irritation of the foreskin leads to masturbation, etc., and (3) that its removal increases sexual enjoyment and the liability to conception. In answer to the first it may be said that in most cases in early infancy before the prepuce has ever been retracted, the glans will keep itself clean. At a later period, during boyhood and adult life, it is a very simple matter to expose the glans once a day and wash with plain warm water. In the second place it is more than doubtful whether the presence of the foreskin tends to masturbation, ex-

cept it is unusually long or the orifice too small, in both of which cases circumcision is undoubtedly the remedy. In the third place, as sexual tendencies are already too strong in most men—are out of all proportion to other appetites—there seems to be no good reason for performing an operation to increase the passion. Then, as most married women are racking their brains to devise some method of preventing conception, this excuse is disposed of.

With regard to the Jewish ceremony of circumcising every male child at the age of eight days by a rabbi who has no knowledge of surgery, and in consequence often makes the most bungling operation imaginable, there is no question that it should be absolutely prohibited by law. The writer has seen the most outrageous mutilation caused by Jewish rabbis undertaking to perform a delicate operation which requires considerable surgical skill.

So much for negative arguments. On the other hand, the healthy prepuce should not be interfered with for the following reasons:

1. The foreskin covers the most sensitive portion of the human anatomy, the glans. It is evidently there placed for protection and comfort, and it gives both. When it is removed the delicate mucous membrane of the glans is gradually toughened so as to stand the irritation of the clothing, and *mucous membrane was never intended to take the place of epidermis.*

2. It is a question whether this constant irritation does not tend to cause masturbation quite as well as the elongated foreskin. Circumcised boys certainly masturbate.

3. To remove the prepuce in a healthy child is, in the opinion of the writer, a useless, dangerous and wholly unjustifiable operation.

A CASE OF MELANOTIC SARCOMA OF THE NARES.

BY I. G. SHALLCROSS, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

OF about forty reported cases of sarcoma in the nasal passages, four have been melanotic. The case reported here is that of a German lady æt. 72 years, who applied at the Hahnemann dispensary, August 7, 1891, for what had been called a polyp of the nares. A year ago she was quite stout, but is now emaciated.

She complained of not feeling strong enough to attend to her household duties. Last summer she had "la grippe." As this catarrhal trouble disappeared, she noticed a stuffiness of the left nostril, gradually increasing to complete stenosis. In April she consulted a physician, who removed part of the growth with a pair of scissors. This operation was followed by a profuse hemorrhage, lasting two hours. Four weeks after the first operation the growth recurred, and again a portion of the tumor was removed. This time, the bleeding was controlled in one hour. During the three months following nothing was done for her condition, although the tumor continued to grow, complete stenosis again resulting. For six weeks previous to applying

FIG. 1.



Appearance of Tumor Before Operation.

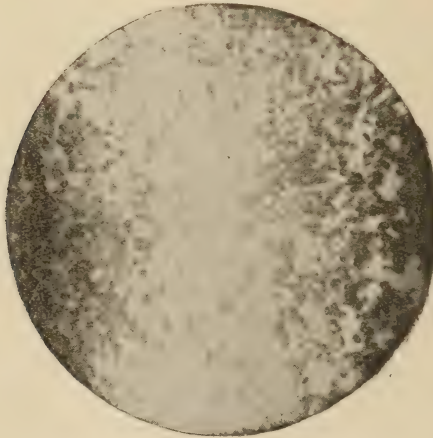
at the dispensary she had frequent attacks of epistaxis; pain developed around the left eye; and she lost strength and flesh rapidly. At times, she was flighty in her conversation.

The nose was considerably bulged on the left side, otherwise nothing could be seen externally. Separating the alæ of the left nostril, a large bluish-black growth, entirely filling the anterior nares, almost protruded from the nose. There was a profuse sero-sanguinolent discharge and slight fetor. The growth was very slightly movable; of a boggy consistence, and attached to the triangular cartilage of the septum by a broad, flat pedicle. There were, also, adhesions to the middle and inferior turbinated bones. The right nostril was

perfectly normal, except for a slight deflection of the septum, due to the pressure of the tumor, on the left side. A post-nasal examination, with Fränkel's rhinoscope, revealed nothing abnormal. The lymphatics were not involved.

On August 15th, she submitted to an operation for removal. A four per cent. solution of cocaine was applied to the mucous membrane, and an attempt made to remove the tumor by means of a Sajous snare. About one-third was removed in this way. Failing to snare more of the growth, even after breaking up the adhesion to the turbinated bones, I employed the sharp spoon, and by this means removed the entire growth, the tissue breaking down readily. It now became

FIG. 2.



Showing Hæmorrhage and Necrosis.

necessary to tampon the nares in order to control hæmorrhage which was quite profuse. In about ten minutes the tampon was removed, and the entire anterior two-thirds of the nares tightly packed with iodoform gauze. This was allowed to remain for three days, when it was removed and the nares cleansed with an antiseptic solution, after which it was redressed with the gauze. On August 22d, the base was thoroughly curetted, and cauterized with chromic acid, and again packed with the iodoform gauze, which was removed at the end of three days.

September 8th, she reports still feeling weak. There has been no recurrence of the epistaxis; the pain is entirely gone, and her mind is clear.

The future treatment of the case will consist in frequent cleansings

with antiseptic solutions, and the administration of such remedies as her symptoms may indicate. The case will be carefully watched, and the slightest recurrence will be met by prompt curetting and cauterization. Should I not be able to control and eradicate it by such means, the entire triangular cartilage to which the original growth was attached will be removed.

Several pieces of the growth were kept for microscopic examination, and these examinations revealed a round-celled sarcoma, fully one-third of the cells and much of the intercellular substance being colored with a dark-brown pigment, proving the case to be one of round-celled melanotic sarcoma. Numerous hæmorrhages had taken

FIG. 3.



Showing Pigment.

place in the tumor, and around the edges of the hæmorrhagic points were found marked necrosis.

In conclusion, I must mention the fact that, when this patient first applied at the dispensary, on August 7th, hamamelis was prescribed with the happy result of checking the epistaxis, there being no return during the time intervening between the operation and August 16th. At present, I believe china to be the remedy most thoroughly indicated in her case, but I have in mind such remedies as ars., carbolic ac., hydras., thuja, con., cal. carb., phos., phy., sepia, and silica. Considering the great malignancy of these tumors, however, I am firmly convinced that they should be removed immediately, if the operation is possible.

HEADACHES FROM EYE-STRAIN.

BY D. A. STRICKLER, M.D., ST. PAUL, MINNESOTA.

(Read before the Minnesota State Homœopathic Institute.)

THE subject of headache is not a new one to the physician. Who of you can not recall numerous cases of chronic headache, varying from slight neuralgia to fearful attacks of sick headache in which the sufferer is laid up for a day or two from every little indiscretion in diet, exercise or excitement, and many times from no discoverable cause? These cases almost invariably baffle the physician in all his attempts to relieve; they continue to come in spite of all that can be done, and run their course, perhaps slightly modified by treatment, but in few instances relieved to any extent. The popular remedy at present seems to be some preparation of coal oil, such as antipyrine, antifebrine, antikamnia, etc., all of which have but a temporary effect.

In many of these cases an examination of the eyes reveals an error of refraction, or eye-strain in some of its forms, and glasses greatly mitigate or entirely relieve the suffering. That the gastric symptoms accompanying sick headache, and which are so frequently ascribed to "inactive liver," "dyspepsia," "too high living," etc., may be due to eye-strain is a very simple matter to understand when you recall your boyhood experience with your mother's and grandmother's glasses; how at first they made you dizzy, and a little later feel somewhat uncertain about the stomach. It is not an unusual occurrence for glasses, not fitted, to produce headache, vertigo and sick stomach, showing clearly that a sympathy exists between the eye and the stomach. What is true of eye-strain from wearing improper glasses must be equally true from not wearing glasses when they are needed. My aim in writing this paper is to show what classes of headache have been relieved by wearing glasses prescribed by the writer. With this in view I have made a somewhat extended analysis of 313 cases of errors of refraction, examined principally in the past eighteen months. Of these 313 cases, 91 were males and 222 females. Headache was complained of in 73 cases; of these 73, 11 were males and 62 females. Of the males, eight were cured, one has not reported, and two did not take treatment nor prescription. Of the females, 26 were cured, 15 benefited, most of them greatly; three received no benefit, 11 have not reported, and seven

took no treatment or prescription. Of the 73 cases of headache, insufficiency of the recti muscles is recorded in 32; of these, eight were insufficiency of the external recti. The errors of refraction include all forms save mixed and irregular astigmatism, the proportion being as follows: hyperopia, 20 times; myopia, three times; hyperopic astigmatism, 22 times; myopic astigmatism, three times; compound hyperopic astigmatism, 17 times; compound myopic astigmatism, seven times; presbyopia, once. Of the 313 cases, hyperopia occurred in both eyes 114 times; in one eye alone 14 times. Myopia occurred in both eyes 26 times; in one alone four times. Simple hyperopic astigmatism occurred in both eyes 44 times; in one eye alone seven times. Myopic astigmatism in both eyes seven times; in one eye alone three times. Compound hyperopic astigmatism in both eyes 38 times; in one eye alone 25 times. Compound myopic astigmatism in both eyes 10 times, and in one eye alone seven times. Mixed astigmatism in both eyes six times; in one eye alone twice. 63 cases were presbyopic.

We thus find that headache was complained of in about 16 per cent. of H.; 10 per cent. of M.; 43 per cent. Ah.; 30 per cent. Am.; 27 per cent. of H. + Ah.; 41 per cent. of M + Am., and in no case of mixed astigmatism, while in one case presbyopia alone existed, thus giving much the larger per cent. in the various forms of astigmatism.

In taking up cases I will give examples first from the males.

CASE 1 (72).—Eddie L., æt. 14, schoolboy, H + Ah., cure.

History of headache, commencing while in school the year before, and necessitating his giving up school before the term was finished. Was free of headache during the summer, but it came on in the fall shortly after he entered school, and increased so that not a day passed without headache, which was worse in the afternoon, until it was thought necessary to take him out of school again. Examination revealed a manifest Ah. of 1. D. in each eye. Under a mydriatic R. E. required + 3. D. s. \bigcirc + .75 D. cy. L. E. + 1.25 D. + 1 D. cy. for corrections,

R. R. E. + .75 D. s. \bigcirc + .75 D. cy.

L. E. + .25 D. s. \bigcirc + 1. D. cy. was prescribed for constant use. He immediately entered school and continued through the term without a headache. When last seen he said his eyes had given him no trouble whatever since wearing glasses.

CASE 2 (164).—W. H. B., æt. 43, Am., cure.

History of headache for years; came on about once in two weeks, and always ended in vomiting. This gentleman did not connect his headache with his eyes at all, and when I suggested that there

might be some connection he argued that there could not be, since he could see as well as anybody, and his eyes had at no time felt badly; besides, he could always trace his sick headaches directly to indiscretions in diet. When the headache came he always gave up the day to it, and seemed to think it a pretty tough day.

Examination revealed Am. of 1.75 D. in each eye. These glasses were prescribed for constant use. One year later the report was, "Not a headache since wearing glasses."

CASE 3 (226).—J. L., æt. 20, Bookkeeper, M., cure.

Headaches all the time; much of the time "frightful." Headache as if the head would fly to pieces, worse motion, especially stooping; "throbbing as if the heart were in the head," and relieved by nose-bleed of bright red blood; hæmorrhages, fearful in character, preceded by darkness under the eyes, nearly black at times. Headache always worse from the sun. This was a case of progressive myopia, and was treated for a time by remedies, such as glon., jaborandi, physostig., picric ac., phos. ac., etc., until the headaches were greatly mitigated, then his myopia was corrected by a —4.50 D. glass for distant use.

This young man had had these headaches for years, as many as five; he had been treated homœopathically and otherwise, had consulted an oculist before, whose record he gave me,—all apparently with no benefit. His improvement with the remedies mentioned was from the start, and though I have not treated him for about a year, he told me only recently that he was using his eyes a great deal, and that he did not have headaches or nose-bleed. Whether the error of refraction was to any extent responsible for his troubles, or whether it was a brilliant example of homœopathic remedies, I am unable to say, but to me the results are very gratifying.

CASE 4 (271).—M. S., æt. 12, Schoolboy, H., choreic.

For past six months has eye pains and headaches when he attempts to read for a few minutes; with this the child is choreic. The chorea was of four months' duration, first noticed in the face, gradually extending until it involved the left arm and left leg; later was troubled with deranged digestion, sleeplessness, etc. The boy was found to have a manifest hyperopia of .75 D., which was corrected by glasses, with entire relief of eye pains and headaches, as well as of chorea and other symptoms.

CASE 5 (282).—C. E. S., æt. 33, Reporter, Ah., cured.

Headaches almost daily; pain mostly in eyeballs, temples and occiput. When in the occiput it seems to draw the head back, and he uses antipyrine for relief. Headache mostly in the morning. He has tinea tarsi. Examination revealed Ah. of 50 D. in l. e., for which a .50 D. cy. was prescribed. He reports, "No headache since wearing glasses."

In this case we find "tinea tarsi" recorded. Experience shows that in nearly all cases of "tinea tarsi" there is an error of refraction, the correction of which greatly facilitates their treatment, and many of which cannot be cured without such correction.

Selecting from the list of females, we have the following:

CASE 6 (70).—Miss J. B., æt. 24, seamstress, Ah., cured.—Headache nearly all the time; begins as soon as she commences to read or sew. If she continues to use the eyes gets sick at the stomach, light dazzles and everything blurs. Examination showed H. + Ah. The Ah. was corrected and the headaches relieved.

CASE 7 (120).—Miss A. W., æt. 33, office-girl, H., benefited.—Headache after using the eyes a short time, especially on the right side of the forehead; sensation as if the eyeballs were drawn back by a string. This case had a manifest hyperopia of .75 D. o. u., a total hyperopia of 2.25 d. in r. e. and 1.50 D. in l. e. She was given + .75 D. o. u. for reading, which gave her only partial relief from headache. The symptom "sensation as if the eyeball was drawn back by a string" not being relieved from glasses, quickly disappeared when Paris quad. 30 was given. In this case a slight insufficiency of the external recti was found, but I was not enabled to follow the case with treatment for the weakness, as she lived at some distance. Whether such treatment might have entirely relieved her I am, of course, unable to say, but it has done so in many cases not at first fully relieved.

CASE 8 (149).—Miss M. E. B., æt. 27, College, H., partial relief.—Is subject to headache for the past eighteen or twenty months, affecting the forehead and temples; worse the latter part of the day. There is a disposition to press on the eyes after use; but little blurring of print. Insufficiency of internal recti at $20' = 1\frac{1}{3}^\circ$ at $20'' = 7^\circ$. This case took a few exercises with prisms, and when last reported had insufficiency at $20'' = 0$. at $20'' = 2^\circ$. She had spheres prescribed for hyperopia, with the effect of lessening the frequency of headaches, but not their intensity.

CASE 9 (168).—Miss A. C., æt. 19, School, H. + Ah., Cure.—Has been subject to headaches for the past five or six years. Pains are just back of the eyes; thinks the l. e. turns up; eyes feel as if crossed with occasional diplopia. Internal recti in sufficient 3° at $20''$. A low degree of hyperopia with hyperopic astigmatism was found. The Ah. was corrected, after which she reported entire relief from eye and head symptoms.

CASE 10 (180).—Mrs. W. H. D., æt. 31, Housewife, Ah., Cured.—History of sick headache for years, affecting principally the forehead and occiput—brought on from reading, riding in the cars, or street-cars; going into a crowd; going to theatre; shopping, excitement, etc. Eyes reddened on use. Photophobia and tinea tarsi existed.

Examination revealed that what at first appeared to be myopic

astigmatism was, in reality, hyperopic astigmatism with spasm of the ciliary. The case had full correction with cylinder prescribed for constant use, and reported after six weeks use: "I can do anything now. Don't have headache any more." She has since said that she couldn't keep house without her glasses.

This was a typical case of sick headache coming on from slight and various causes. The patient had, at no time, thought her eyes accountable, and had made up her mind that she would have to go through life a martyr to sick headaches, as had her mother before her. Her coming to me was simply an accident, she having come with another patient, and in questioning her friend in regard to headaches she told her story. The thought that her headaches might be due to eye-strain was a revelation to her, and she looked upon the result of glasses as almost a miracle.

CASE 11 (102).—Miss Nellie D., æt. 28, Teacher, Ah., Cure.—Has been near (?) sighted for many years, but past three years has felt more strain on the eyes. Has headaches—thinks from strain, mostly at night, or when she first gets up in the morning; photophobia from bright lights. Reads J. No. 1 at 7" normally.

Examination gives vision $\frac{2}{20}$ with both eyes; improved to $\frac{20}{15}$ with —.50 D. cy. Insufficiency of internal recti of 4° at 20', also at 20". Under a mydriatic the case resolved itself into Ah., which was fully corrected, with the result of giving her complete relief and causing her to hold J. No. 1 at 12" to read normally.

CASE 12 (203).—Miss Louise H. G., æt. 24, Teacher, H — Ah., Cure.—Asthenopic symptoms for the past five years—more especially since school opened three months ago, since which time she has had severe and frequent headaches in the forehead, sinciput, and occiput after using the eyes. Eyes red; slight conjunctivitis. Holds her reading 9" from the eyes.

Examination gives vision $\frac{2}{20}$ in each eye. Will not accept glasses. Insufficiency of external recti of 2° at 20' and at 12". Prismatic exercise was advised, which entirely relieved the insufficiency, but did not relieve the æsthenopia or headache. She continues to hold the print at 9" for reading.

A mydriatic was then used and revealed a compound hyperopic astigmatism, corrected by .25 D.s. $\odot + .25$ D. cy. in each eye. The hyperopic astigmatism was corrected with relief of all symptoms. She expresses herself as "delighted" with her glasses.

I have placed 11 and 12 together, because they are representative of a class of cases, numerous examples of which I have met with, and for which I am not able to give any very satisfactory explanation. I refer to their holding print *near* the eye to read, when they have

practically normal distant vision. In nearly all I have found a low degree of As., principally Ah., with some slight insufficiency of one or more of the recti muscles. Slight spasm of the ciliary does not seem to me to account for it, since the distance does not vary in years. Then, there is not the incentive to enlarge the retinal image which exists in the amblyopic eye. The effect of weak cylinders has, I believe, been satisfactory in every case.

CASE 12 (186).—Miss Daisy D., æt. 16, College. H. + Ah. in one eye. Cure.

Subject to headache all her life, but worse since in college. Headache in centre of forehead and high in the occiput; worse mornings and after dinner. Tendency to press on the eyes, which gives some relief. Some photophobia.

This young lady was found to have compound hyperopic astigmatism of the left eye, the right one being emmetropic. A glass of + .75 D. s. \ominus + .50 D. cy., which fully corrected the error, was prescribed, with the result of entirely relieving her of her headaches and eye-symptoms.

CASE 13 (189).—Annie E., æt. 12, School, H., cure.

Since seven years old has been subject to headaches, which have been on the increase: worse especially when in school. Has headache nearly every day; may commence any time in the day and may leave in the evening or during the night. Headache principally in the forehead and temples; with headache eyes feel as if being pulled into the head with a string. Internal recti insufficient 2° at 20'; 6° at 12". Total hyperopia of R. E. + 1.50 D. L. E. + 2 D. Rx. R. E. + 1. D.; L. E. + 1.5 D. was given for constant use, with partial relief of headache, insufficiency remaining about the same. Prismatic exercise was advised, with relief of insufficiency at both 20' and 12", and entire relief of headache. Last report was, "No more headaches, and I'm getting fat."

CASE 14 (297).—Augusta W., æt. 25, housework, H. + Ah., cure.

Burning, smarting, on reading or sewing, with disposition to press on the eye for relief. Headache since a child, principally in the forehead, but occasionally in the occiput. Headache almost constantly for past six months; at times excruciating in character. Chronic conjunctivitis.

Examination gave compound hyperopic astigmatism, corrected by + 1. D. s. \ominus + .25 D. cy. in r. e., and + .75 D. s. \ominus + .25 D. cy. l. e. Rx. R. E. + .50 D. s. \ominus + .25 D. cy.; L. E. + .25 D. s. \ominus + .25 D. cy. was given, with partial relief of headaches. Prismatic exercise was given, with the effect of entirely relieving the headaches, but it did not eliminate the insufficiency.

Cases 13 and 14 illustrate the class of cases in which glasses give but partial relief, and in which prismatic exercise comes to our relief.

While the insufficiency in case 14 remained the same after exercise, the internal recti overcame very much stronger prisms, which accounts for the effect on headaches, by the internal recti being able to do the same amount of work with less strain. Whether other glasses might have relieved these cases without prismatic exercise, as is claimed by a large contingent of the profession, I am unable to say. Our control of patients is not always so perfect that we can settle these matters by experiment.

CASE 15 (287).—Mrs. Geo. S., æt. 38, Housewife, H. + Ah., cure.

Eyes tire on use; has continually a dazed feeling in the head, increased by over-exertion, physical or mental.

Examination gave a total error of 1. D. s. \ominus .50 D. cy. in each eye. .25 D. s. \ominus .50. D. cy. in both eyes was prescribed, with the effect of relieving the dazed feeling and symptoms of asthenopia.

Of those not benefited, there is only one that I have been able to see more than once; hence, the only one that I am at all definite about could not be benefited by eye treatment. This case I will now report.

CASE 16 (224).—Mrs. R. A. K., æt. 58, Housewife, Ah., no relief.

Has always, since a child, had headaches; headaches were worse when she was menstruating, which ceased twelve years ago. Headaches commence on the top of the head, and after a day or two go to the temple and around the left eye. Eyes are very sensitive to touch during the headaches; the bones are very sore after headaches. Eyes feel dry; lids heavy at night, at times has difficulty in opening them; pain on use.

A low degree of Ah. was found and corrected, as well as the presbyopia, but with no relief of headaches. This case remained under observation, but failed to yield to anything that suggested itself to me. She gave a history of chronic constipation, extending over the period of her headaches, and may have been a suitable subject for the rectal specialist.

There were other cases of equal interest to the ones here recorded, but I believe none that presented features not represented in one or more of these cases. The lesson that may be drawn from these cases is, it seems to me, that the classes of headaches that may be relieved or benefited by eye treatment, are numerous and not especially well defined. It would be difficult or impossible to say, in any given case, without a careful examination, that an error of refraction, or eye-strain in some form, is not accountable, to some extent, for the

headache. On the other hand, it is not safe, in any given case, even with careful examination, to make definite promise of cure. The large percentage of cases in which benefit has been given leads us to hold out hope in nearly all cases.

In a general way it may be said that where eye-strain is a prominent factor in the production of headaches, asthenopic symptoms will be present. By asthenopic symptoms I refer to a sensation of weakness in the eyes, a tired feeling on use, blurring of print or running together of the letters, an unsteady feeling in the eyes, etc. Frequently a sandy feeling is complained of; again, a disposition to press on the eyes with the fingers, or to close the eyes for a few seconds. Car sickness and vertigo from looking at striped goods are frequently complained of in astigmatic cases. One or more of these symptoms may be present, *but are not essential* to make it a case of eye-strain.

The characteristic localities of pain in the head are, first in the eyes, next in the temples or over the eyes, and next in the occiput. I am not quite sure that occipital headache should not have a more prominent place, as it is frequently complained of. Last in the list I would place pain on the top of the head. I believe I have never seen a case greatly relieved by eye-treatment in which the pain was principally on the top of the head, and, as you will notice in case 16, the only one reported that experienced no relief, the headaches commenced on the top of the head, and remained there a day or two before going to the temple and left eye.

It is not claimed by the writer that in all cases relieved by glasses the headache is due directly and alone to eye-strain; in fact I hold that the reverse is true in the majority of cases. What I do believe is, that while in some cases the eye-strain may be the sole cause, in the vast majority of cases it is the eye-strain plus other elements of weakness in the patient. The eye-strain is the "straw that breaks the camel's back," but it is more than this,—it is a whole bundle of straws, the removal of which enables the camel to proceed on his journey in comparative comfort.

IS BOILED WATER TO BE RECOMMENDED AS A DRINK?—Dr. Mignel finds that boiling the water for some time destroys nearly all the bacteria, but does not remove the various salts and carbonic acid, as was formerly held. If boiled water be allowed to come in contact with cold air for a short time it regains the gas lost and its insipid taste disappears. Boiling is the most simple and certain method of purifying water for general use.—*Medicinische Neuigkeiten*, No. 44, 1891.

JOTTINGS FROM PRACTICE IN THE OLD COUNTRY.

BY ROBERT S. COOPER, M.D., LONDON.

(Physician, Diseases of Ear, London Homœopathic Hospital).

EVERY week, every day, there comes before the physician in active practice facts that, if recorded, may prove valuable helps to other workers in the same field, and which, if not there and then recorded, are lost forever to science. Hence it is that I take pen in hand to give a gossiping record of notable experiences met with day by day.

Some months ago I met a gentleman some sixty-five or seventy years of age, who, in course of conversation, told me he had diarrhœa so badly some thirty-five years ago that his life was considered in danger, and that none of the allopathic doctors he had consulted were able to give him any but temporary relief. He then consulted a well-known homœopathic practitioner in London, who, on studying his case, prescribed chamomilla 12th cent. dilution. This gave more relief than anything he had had, and gave him "confidence in the system." As, however, he had occasion to go to Paris, he requested a letter of introduction to a Paris doctor. The Paris consultant arrived at the same conclusion as to the remedy, but instead of prescribing chamomilla in the 12th, he gave it him in the 200th; the result was he got perfectly well, and has so remained up to the present day.

The unfortunate lesson we have to learn from this is, that such a case would run very little chance of being cured with homœopathy nowadays, for the chances of his getting even a 12th dilution from the same practitioner would, I fear, be very small; he would be prescribed a mother tincture or nothing.

Take another: A gentleman about the same age as last was speaking to me a few weeks ago; he was a particularly stalwart, hale and hearty man for his age. Suddenly he turned round to me and said: "Do I look as if I had been paralyzed?" "Paralyzed! God bless us all, indeed you don't!" But I was, though," he returned, "and badly paralyzed; so badly, that the leading authorities in London (I omit the names he gave) gave me up, and Dr. Brown Séquard, who was then over here, declared I should never be able to get off my couch."

"Then what," said I, "in the name of thunder did you do?" "Why," said he, "I went to that cross old devil, Wilson, in Brook street, and he cured me with, I believe, the 200th of *secale cornutum* and here I am, as well as ever, and can take a six-barred gate across country as well as ever I did." So much for scientific homœopathy.

Take another case: A gentleman of about fifty-six years of age was in here a few months ago for a slight affection of his throat. Having examined his throat, I had occasion to take a look at his nostrils, and no sooner had I thrown the mirror upon his left nostril than I exclaimed: "Why, you have horribly bad *ozæna*!" "*Ozæna*!" said he, "No! surely not; but I tell you what it is, doctor, I did have *ozæna* some thirty-five years ago, and my case was pronounced incurable by every man I consulted, till at last I went to old John Epps, and with a 200th dilution of nitric acid he got me perfectly well, and well I have remained to the present moment."

Here, then, was a case with well-marked cicatrices of the mucous membranes covering the spongy bones, with an appearance such as we get in very obstinate cases only of *ozæna*, and in which complete recovery had taken place under the 200th of nitric acid alone.

What on earth chance of recovery would such an unfortunate sufferer have under homœopathy at the present day? But thanks be to heaven, it is men who have changed and not homœopathy. We can still cure cases like these if we are true to our principles, and will patiently study the actions of our drugs.

PYRETOLOGY.

BY EDWARD FORNIAS, M.D., PHILADELPHIA.

FEVERS constitute a class of diseases characterized essentially by an abnormal rise of the temperature of the body, and by an increase of the organic combustions. It is a breaking off of the equilibrium existing between the income and the output of heat. In this process the production outweighs the expenditure, and as a consequence the temperature rises from one to more degrees.

In analyzing the phenomena of *pyrexia* we find of course, that the principal element at work is the *abnormal elevation of the temperature*, and that this is associated with various disorders of the *circula-*

tion, respiration, nervous system, digestive organs, secretions, and with certain changes of tissue. Hence, we must bear in mind, that whenever the temperature of the body transcends the normal limit, certain other phenomena are generally to be found, and these, with the exception, perhaps of tissue-changes, appear to be simply due to the pyrexia.

Such phenomena should be studied in the order given above.

1. *Temperature*.—In health it depends mainly upon the oxidation of the food, and the maintenance of a ratio of repair to waste. In fever it depends principally on the oxidation of the tissues, and this arises under a great variety of circumstances. (Collie.) It will be profitable to define the standard of the temperature in health, before detailing the principal variations in disease. In general it may be said that the corporeal temperature increases from the periphery to the centre. The normal temperature taken in the axilla is estimated to be 98.4° , but while we notice that in the hands and feet rarely exceeds 96° , in the mouth it may reach 99° , and still a little higher in the rectum and vagina. For obvious reasons the place selected to take the temperature is the axilla, sometimes the site chosen is the mouth, but in certain special cases the temperature of the rectum should be ascertained. Again, the normal temperature of the body is liable to slight *diurnal variations*, a *minimum* between 6 and 7 A.M., and two *maxima*, one about 9 or 10 A.M., the other towards 5 or 6 P.M., and in the febrile state these mutations become more marked, the evening temperature being as a rule higher than that of the morning. But in health other fluctuations may be induced by certain circumstances. The normal temperature is *raised* by active exercise, by a long exposure to a great heat, by a residence therefore in tropical climates, and temporarily by hot baths. It is *lowered* by prolonged study or severe mental exertion, by exposure to cold without active exercise, by fasting, and temporarily by cold baths, and a full meal, in the latter case increasing as digestion goes on. The taking of alcohol first causes a fall which does not last long, for it requires a considerable amount to have any material influence. (Charteris.) The presence of these variations should always be borne in mind when taking the temperature for clinical purposes.

Useful guides for the clinical student are those given by Aitken :

1. "Whenever the temperature rises to about 99.5° , or a depression below 97.3° takes place, there is surely a sign of some kind of disease, if the change is persistent." 2. "In febrile diseases, an increase to 100° or 101° , only signifies a mild attack; a constant temperature

of 105° implies severity of disease; a rise to 106° or 107° denotes danger, and a fatal termination may be expected if the thermometer rises to 109° or 110° ." In other words, when the corporeal temperature rises to any point below 101° , the pyrexia is slight; any rise above 101° or below 103° indicates a moderate pyrexia; beyond 103° up to 106° is the sign of high fever; above 106° the term hyperpyrexia is used. But in disease the temperature may, instead of rise, fall below the normal.

Wunderlich has classified the febrile temperatures, and the temperatures inferior to the normal, which he has called temperatures of collapse, as follows:

FEBRILE TEMPERATURES.

	C.	F.
Slight fever,	38° to 38.5°	100.4° to 101.3°
Moderate fever,	38.5° to 39.5°	101.3° to 103.1°
High fever,	39.5° to 40.5°	103.1° to 104.9°
Hyperpyrexia,	42° and above.	107.6° and above.

COLLAPSE TEMPERATURES.

	C.	F.
Modern collapse,	36° to 35°	96.8° to 95°
Algid collapse,	35° to 33.5°	95° to 92.3°
Lethal collapse,	33° and below.	91.4° and below.*

The same authority observed a case in which the temperature rose to 112.55° . The greatest fall he has noticed is 89.6° . Temperatures above 107° are very rare. According to Roberts, remarkably high temperatures have been recorded in some cases, but there can be no doubt (he says) that these were not real, and that the patients practiced deception. "The nervous system influences heat production, as well as heat regulation."

A *sub-normal temperature* may be observed in acute collapse, myxœdema, intestinal obstruction, cerebral hæmorrhage (early), remittent fever (during recovery), intermittent, chronic wasting diseases, and in pyrexia, when death is impending.

Slight rises of temperature (up to 101°) are observed in gastric dis-

* *Rule*.—To convert Centigrade into Fahrenheit, multiply by 9, divide by 5, and add 32.

Example.— 37° C. $\times 9 \div 5 + 32 = 98.6^{\circ}$ F.

Rule.—To convert Fahrenheit into Centigrade, deduct 32, multiply by 5, and divide by 9.

Example.— 104° F. — $32 \times 5 \div 9 = 40^{\circ}$ C.

turbances, in tetany, worm affections, dentition; too abundant alimentation, during convalescence, during a single epileptic fit, or they may occur during the emotions or fatigue.

Moderate elevations (from 101° to 103°) are noticed in pleurisy, dysentery, subacute articular rheumatism, measles (rarely 104°), and in tubercular and epidemic meningitis.

High temperatures (from 103° to 106°) are found in eruptive, intermittent, remittent (hot stage), typhoid, typhus and relapsing fevers, as well as in pneumonia, peritonitis, meningitis, acute articular rheumatism, erysipelas, pyæmia, and phthisis.

Hyperpyretic rises (from 107° to 112°) are mainly met with in sunstroke, tetanus, *status epilepticus*, septicæmia, and rheumatic fever. They occur occasionally in typhoid and scarlet fevers. Becard has demonstrated that a muscular contraction produces more heat when it is *statical*, that is unaccompanied by a mechanical work, than when with it a useful mechanical act is performed, that share of muscular force not put to use under the form of an exterior mechanical work, appearing under the shape of heat. It is for this reason that in tetanus as well as in the *status epilepticus* we see the temperature rise, in a short time, several degrees, under the influence of the muscular tonic contractions. On the other hand, Dr. Pollock, of England, asserts that it is in connection with acute rheumatism that hyperpyrexia has attracted most attention and is most frequently encountered. Curiously enough (he says), it is not only the more severe attacks of the disease that drift into hyperpyrexia; comparatively mild and subacute cases, which appear to be doing well, will now and then take this remarkable course.

During the course of all fevers we recognize three periods: First period of ascent (pyrogenetic stage of Wunderlich), during which the temperature rises; second, period of acme, climax (fastigium of Wunderlich), more or less prolonged, during which the temperature maintains its maximum or thereabouts; third, period of defervescence or decline, during which the temperature abates to return to the normal standard.

Period of Ascent.—If the rise from normal to maximum takes place in a few minutes or even in a couple of hours, the ascension is called abrupt or rapid, as it happens in febricula, pneumonia and small-pox. If the temperature rises gradually and does not reach its maximum, until three or four days the ascent is then called slow or tardy, and this may be continued or by ascending oscillations, as in typhoid fever.

As the mode of ascension of the temperature is of a great diagnostic value a few examples may not be out of the way here. A rise to 104°, observed on the first two days of febrile affection, precludes the idea of typhoid fever (Wunderlich), but not so with children, for in infantile typhoid high rises are noticed at the outset. (Kunze.) At the beginning of the second week of typhoid a temperature of 102° or 103° in the evening may be found in a mild and 105° in a severe case. If the temperature falls at this time, the case is not one of typhoid. When any special complication is likely to occur, such as hæmorrhage, the temperature rises, and this is true of other diseases, such as tuberculosis. At the end of the third week or so, a fall (especially towards evening) in typhoid is a sign of approaching convalescence, and it has a favorable significance even if the pulse keeps high. A rise has a contrary significance. (Tanner.) Characteristic is also the gradual ascent of the temperature during the first three or four days in typhoid fever, thus; On the

	A.M.	P.M.
First day,	98. 6° F.	103. 3° F.
Second day,	100.22°	103.56°
Third day,	101.66°	103.64°
Fourth day,	102.56°	104.54°

It will be seen from the above table that every evening the temperature is about 2° F. higher than in the morning, and in the morning 1° F. lower than the previous evening, till on the fourth evening a temperature of 104° or 104.52° F. is reached. (Husband). The same authority excludes typhoid in the following manner:

1. If the temperature on the evening of the second, third or fourth day are only approximately normal.
2. If the temperature on the first three evenings be the same.
3. If the temperature on two of the first three mornings be the same.
4. If the temperature on the first two days rises to 104° F.

“The temperature during the latter part of the first week and the early part of the second is almost uniform. The maximum is reached on or about the fourth day, and then remains stationary for a day or two, decided defervescence not taking place until the twenty-first day.”

“During the third week the temperature shows a marked difference from that of *typhus*. In *typhus* the normal temperature is regained about the fourteenth day; in typhoid the fever is continued

into the third week. When the temperature for two successive evenings has closely approached to normal, convalescence has set in."

In ague a rise precedes by several hours the febrile paroxysm, and if the temperature continues at an elevated range the disease still has its hold on the patient. (Tanner.) The thermometer placed in the mouth, rectum or axilla, will show that the temperature in the cold stage is already considerably above normal (102° or 104°). Indeed, it commences to rise some minutes (or even one or two hours) before the rigor, the sensation of cold and the actual cold of the surface being due to contraction of the superficial vessels. Towards the end of this period the temperature attains a higher range, 105° or 106° , rising still higher during the *hot stage*, 106° or 107° , and may become hyperpyretic, 110° or 112° , in hot climates. And so we have a rapid ascent, two marked elevations, a short stationary period, critical defervescence and normal in the intervals.

In remittent fever the temperature rises 1° or 2° during the cold stage, may reach to 104° or 106° during the hot stage, and fall to 100° or 99° during the sweating state. It is an ague, the temperature of which does not intermit, but only drops somewhat; the cold and sweating stages are, therefore, poorly developed, but the hot stage is longer than in intermittent fever and may last more than twelve hours. This fever approaches to the continued type and is correspondingly serious. The prognosis is more favorable the more marked the remissions. (Money.)

In pneumonia a rapid rise to 104° or more takes place and in a large proportion of cases the temperature falls to normal (defervescence by crisis) between the fifth and tenth day. "A temperature of 101° is favorable, since no great or serious change can go on in the lung, especially of a suppurative kind, without much greater elevation; 104° would indicate such an event." (Tanner.) A *sudden increase in the temperature*, during the stage of congestion, marks the invasion of another lobe of the lung. The temperature, which may have been marked by much variation, increasing as successive portions of the lung become diseased, may vary from 102° to 104° at the last stage (gray hepatization). When the temperature falls, the physical signs will indicate that the lung has become more or less consolidated. (Husband).

In measles the temperature increases until the height of the rash, rarely above 103° . It is worthy of notice that the fever does not abate on the appearance of the eruption; on the contrary, we notice that the temperature is highest thirty-six hours from the commence-

ment of the rash. "If the temperature has fallen in the prodromal stage, it rises again, with the appearance of the rash, to 102° , 103° or even higher, and reaching a maximum (104° and above) in two, three or four days, falls generally rather suddenly as the rash begins to fade, and may reach the normal in about thirty-six hours." (Taylor).

In variola (primary fever), the temperature rises rapidly; may reach 104° to 106° , or even higher, with slight morning remissions. The primary fever abates with the appearance of the rash, the temperature suddenly subsiding; then secondary fever sets in (period of suppuration), and the temperature rises again to 104° or 105° , thus differing from measles, where, with the appearance of the eruption, the temperature usually rises to a greater height instead of subsiding. Defervescence is gradual, but desiccation may cause another elevation. The irregular course of rise and fall continues until about the eighteenth day, when the normal is reached.

In scarlatina, the temperature usually rises until the rash reaches its height, then remains stationary, and subsides as the eruption fades. It ranges from 104° to 106° , and may become hyperpyretic (especially in the *anginose* variety), and there is no noticeable remission. In the *anginose*, the temperature continues high after the rash has disappeared. Husband gives to this fever the following course: The temperature on the evening of the second day is about 105° ; it may then rise on the third day a little above (105.8°); and from that day until about the ninth day, it vacillates between 103.8° and 102.9° . On the tenth day it falls to 100.9° , and then defervescence continues uninterruptedly until the normal temperature is reached, about the fifteenth day. Sydney Ringer has shown (says Husband) that the temperature in scarlet fever falls on the fifth day of the disease, then on the tenth, and so on, each fall being separated by an interval of five days. "The temperature is often subnormal during the earlier part of desquamation." (Carter.)

In erysipelas, the fever varies with the severity of the attack, the cutaneous implication being the main determining factor. "In some cases, perhaps more often when the erysipelas is not extensive, the temperature may not rise above 102° ." (Taylor.) From the outset, the course of the temperature is usually the following: A rapid ascent up to 102° or 103° on the first evening of the eruption, increasing with the inflammatory process until it reaches a maximum of 104° or 105° on the third or fourth day. On or about the sixth day, in favorable facial cases, the temperature falls suddenly to nor-

mal in from twelve to thirty-six hours, but it may remain high if the local disorder persists, or may rise again with any fresh cutaneous outbreak; and so we may have sudden and abrupt rises and falls before convalescence is well pronounced. A rise of temperature is always an early indication of relapses, extensions, or complications, and there are great deviations when the disease attacks other parts. Evening exacerbations are usual, but, exceptionally, the morning temperature may be from 2° F. to 5° F. higher. (Carpenter.) In erysipelas migrans, the fever may terminate with a lysis.

In rheumatic fever, the temperature rises from 100° to 104° (may reach 112° , and continue to rise after death). (Carpenter.) The ascent lasts about a week; then a stationary period of variable duration. Defervescence is gradual and indefinite, rarely by crisis. Relapses are frequent. A rise to 104° would be followed most likely by *pericarditis*. (Tanner.) Hyperpyretic rises are common, even in comparatively mild cases. (Pollock.) They are usually announced by a cessation of the pain, of the arthritis, and, in most cases, of the sweating, with increased restlessness and delirium. Cerebral rheumatism, in which convulsions and coma constitute the central signs, is probably always attended with hyperpyrexia, and, apparently, due to it. (Money.)

In general or miliary tuberculosis, the pyrexia is of a somewhat irregular type, generally high in the evening and much lower in the morning; thus, the evening temperature may range from 100° to 103° , the morning temperature from 98° to 100° . Sometimes the *typus inversus* is present, the morning temperature being high and the evening low. (Taylor.)

Acute tuberculosis, at the period of acme, presents a sub-continued type of fever, the diurnal fluctuations sometimes amounting to several degrees. The temperature falls to normal in the morning, and rises up to 102° or 104° in the evening, and the fever at that time may resemble intermittent, but an intermittent in which the paroxysms generally return in the evening, contrary to what takes place in ague. This affection is often confounded with typhoid fever, but the course of the temperature should be sufficient to distinguish them. It is cyclic, regular in typhoid; acyclic, irregular in acute tuberculosis; but, of course, the examination of the thermic traces are not conclusive in all cases, for typhoid may present marked thermometrical irregularities, while the trace of acute tuberculosis may resemble that of typhoid at the climax. (Laveran and Teissier.)

In acute phthisis, the temperature rises to 101° , 102° , or 103° ,

being higher in the evening than in the morning, but the ascent is irregular, and the amplitude of the morning and evening oscillations very marked. (Tardieu.) A high temperature indicates active mischief or an increase of disease. If hæmorrhage occurs, and there is no rise in temperature, there is no reactive pneumonia set up around the hæmorrhagic spots. (Tanner.)

In chronic phthisis, the fever generally bears some relation to the activity of the tubercular process. As a rule, the greater the amount of tubercle produced, the higher the temperature is raised. On the other hand, as the formation of tubercle ceases, so the temperature falls towards the normal standard, but fever is often present continuously for months. The temperature is commonly higher in the evening than in the morning, and is either remittent or intermittent in type. In the former it may be 99° to 100° in the morning, and 102° or 103° in the evening. In the latter it is 98.4° , or even lower, in the morning, and reaches 100° to 103° in the evening. (Tailor.) But the fever varies in the different stages of the disease. In the first period (consolidation), it appears with the first symptoms, and coincides with the formation of tubercle. (Wunderlich, Peter.) The paroxysms occur principally in the evening, from 4 to 7 P.M., and are followed by profuse sweats during the night or in the early hours of the morning. According to Peter, there is always a local elevation of the temperature in the side of the lung first attacked, and where the lesions are most advanced. In the second period (softening), the fever presents always an increased evening exacerbation. The temperature varies from 101.3° to 103.1° , rarely reaching 104° . In the third period (excavation), the fever assumes the hectic type, with the marked variations of the medium quotidiens, and persists with this character until the end of the malady. It is not rare to observe at that time a notable decrease of the fever, due to inanition or to a slow asphyxia; more rarely a final rise may take place under the influence of probable putrid reabsorption. (Hanot.) According to Tardieu, the fever usually appears in the second stage, but, if already present, becomes more intense. The evening rises are most marked, and are preceded by chilliness and followed by profuse sweats, sometimes with such regularities as to resemble a quotidian intermittent. The returning daily rises, if persistent, mark the approach of dissolution.

Cerebral hæmorrhage may be attended with pyrexia, but at first a slight fall of the temperature may be noted (even 2° F.), and this fall may increase if death is very rapid. If life is prolonged the

temperature rises even to 101° , and may so remain for days. In other cases, more especially in pontine hæmorrhage, the initial fall is soon followed by a rapid rise which may reach the hyperpyretic degree. This is regarded as of very serious prognosis. Hæmorrhage anywhere in the body generally causes a fall in temperature; the rise occurring in brain cases must be attributed to a direct influence on the thermogenetic apparatus. (Money). When febrile diseases terminate in death, we observe in the last hours, sometimes an abrupt elevation, at others a collapse. (Laveron and Teissier).

It is plainly seen, therefore, how careful, daily, thermometrical observations will aid us not only in detecting the character of an attack of disease, and the likelihood of complications, but also help us materially in the formation of a prognosis. In reference to this last point, I may finally say that whenever convalescence is about to be established, a regular fall of the temperature will be noted, especially towards the evening. As, therefore, a gradual rise from morning to evening is bad, the reverse is equally favorable. A high evening temperature means an incomplete recovery, or the probable occurrence of some complication—such as suppuration, etc. On the other hand, as soon as inflammatory tissue-changes in any disease come to an end, the temperature falls. Of course, it is implied that other symptoms do not get worse, or they improve; for if the temperature falls, and the pulse beats higher, and the symptoms generally assume a graver aspect, then the prognosis is bad. Lastly, in convalescence, a rise in temperature indicates a probable relapse; and hence the importance of watching the temperature of those convalescent from severe febrile diseases who are not clearly making satisfactory progress. (Tanner).

Period of Acme.—This period may be very short (*fastigium acmeiforme* of Wunderlich), defervescence following closely the ascent; in other cases, after the temperature has reached its maximum, it remains stationary for one, two, or three days (*fastigium with plateau*); and finally it may prolong itself for a week or two, presenting then, either the continued type, in which the temperature maintains itself at about the same degree, mornings and evenings, or the remittent type, in which the evening temperatures are higher than those of the morning, the thermic trace showing then a series of fluctuations more or less marked.

Period of Defervescence.—The term defervescence is used to signify the approach of convalescence as evinced by the fall in temperature. The defervescence, like the ascent, is rapid or tardy. Rapid def-

erescence which takes place in twelve or twenty-four hours is called crisis; it is in fact frequently enough accompanied by phenomena known as critical by the ancient, such as sweats, diarrhœa, abundant urine, herpes, etc. Slow defervescence (*lysis* of Wunderlich) like slow ascensions, present two principal varieties, namely: progressive continued and remittent. In the first the trace-line deviates only a little from its right; in the second the trace-line is broken into descending oscillations, as in typhoid fever. Sometimes defervescence is preceded by an abrupt, but very brief ascent, which has been called procritical.

Ague in its typical forms is a splendid example of a marked attack of fever; there is a sudden onset or cold stage, stage of ascension, followed by a climax or acme, the hot stage, and finished up by a sweating or stage of defervescence.

Accompanying Phenomena: Derangements of the Circulation.—Fever disturbs the circulation in marked degree. The heart beats more rapidly and there is some proportion between the temperature and the increased frequency. The most distinctive feature of the fever-pulse is acceleration. The number of beats at the radial artery runs up to 100, 120, 140 per minute. For every F. D. of fever the pulse rises 8 to 10 beats, so that a temperature of 101° usually gives a corresponding pulse of 90 per minute—supposing the pulse of the individual to beat 66 per minute, when the temperature is 98.4° . (Money.) If the frequency of the pulse were always in relation with the severity of the fever, it would be better to rely on this sign than on the rise of the temperature, for we could count the pulse more speedily than to take the temperature, but unfortunately the sources of error are numerous, for instance, the normal pulse varies in each individual, the least emotion, the approach of the physician, the act of rising, sitting or turning in bed are sufficient to accelerate the pulse of fever-patients. And again in certain febrile maladies, as typhoid fever, the pulse may present a frequency hardly superior to the normal, even if the fever runs high and the thermometer marks 104° . In simple meningitis we notice even a lowering of the pulse. But while we should not entirely depend on the character of the pulse, still we must not forget that this furnishes us a valuable source of information, for there are cases of severe fever, in which the thermometer placed in the axilla gives a normal temperature, and even inferior to the normal, and nevertheless the pulse is small, irregular, accelerated, thus indicating danger. On the other hand, an exclusive reliance on the thermometer could lead us to an unsafe decision.

The febrile pulse is dicrotic, *bis furiens*; it gives to the fingers applied to the radial artery the sensation of a double shock or pulsation, and this phenomenon is traced in the sphygmograph, first by an ascent, then a descent with one secondary elevation, or one curve in the descending line. The amount of dicrotism is in direct ratio to the degree of pyrexia. If the pyrexia be mild the pulse-tracing is sub-dicrotous. When the fall subsequent to the elevation is extreme, it is called hyper-dicrotous, and this is a grave sign. But what in another sense is called a dicrotous pulse—that is to say, a pulse in which two beats occur rapidly to be succeeded by a pause—which is at the same time hard, is also a very unfavorable symptom, especially if it continues more than twenty-four hours; if, however, it is succeeded by epistaxis, and then disappears, it is more favorable. When, however, a hard dicrotous pulse lasts for many days, without any tendency to hæmorrhage, the case—in nine out of ten—ends fatally. The term dicrotic, however, is now generally used, as stated above, to denote a certain pulse-curve obtained by the sphygmograph. (Tanner).

Fever also alters the blood-pressure, which is raised during a rigor, and lowered when the skin is full of blood and the internal viscera and vessels comparatively emptied. So the pulse becomes more dicrotic and more compressible after fever has been present, and as the heart muscle grows weaker the pulse also gets feeble. (Money.)

Troubles of Respiration.—There is almost always an exact bearing between the frequency of the pulse and that of respiration. Instead of from 12 to 18 inspirations per minute in a state of mental and bodily rest we find in fever, 20, 30, 40 inspirations. The pulse-respiration ratio, however, is not only easily disturbed by disease, but also by mental emotion and other agents. Normally the pulse-respiration ratio is 4 to 1, and this natural law makes its influence felt, even during fever, but this influence is not always paramount, as for example, in pneumonia, the ratio may be altered so as to become 2 to 1, the breathing being 60 and the pulse 120. (Money.)

The pulmonary complications, so frequent in fevers, exaggerate necessarily the difficulty of the pulmonary hæmatosis, but the fever is by itself a cause of the acceleration of the respiration, inasmuch as the expenditure of oxygen is greater, and the carbonic acid gas is formed in larger quantities than in the normal state. The researches of Liebermeister have plainly shown, that in all periods of the fever, *the exhalation of carbonic acid is proportionate to the intensity of the*

fever heat, hence the need of a greater activity in the phenomena of exchange of the gases of the blood.

Derangements of the Nervous Systems.—The functions of relation or animal sensation—muscular motion, mental manifestation—are those principally disordered by fever. Of all the sensory nervous phenomena the most distressing are the pains (headache and pains about the trunk and limbs), usually of a *flying* character and sometimes aching and boring. Then comes the chilliness, due to the contraction of the cutaneous arterioles and to the deviation taking place between the peripheral and central temperatures. It is sometimes associated with the motor symptom of shivering, which may be limited to chattering of the teeth, from clonic spasms of the muscles supplied by the motor part of the fifth nerve nucleus, or may extend to the whole body, when the bed or chair on which the patient rests may be violently shaken; or the cold sensations may alternate with sensations of flushing and heat, which are then referred to the vaso-motor system and get the name of vaso-motor phenomena. (Money.) Another common disorder of sensation due to fever is giddiness and this is frequently associated with headache. The chief motor perturbation, and a very common one is restlessness. Common mental disorders are: Malaise, delirium and insomnia. Delirium, stupor, and convulsions, are phenomena of cerebro-spinal excitation. A long continuance of fever gives rise nearly always to an increase in the intensity of the knee-jerk, to the development of ankle clonus by sudden passive dorsal flexion of the foot, to muscular twitches (subsultus tendinum), to muttering or violent delirium, prostration of mental and muscular powers, especially the heart muscle, and sometimes to convulsions and coma. (Money.) The nervous phenomena, however, vary with age. In the adult, for instance, we notice a more or less violent chilliness appear in the moment the temperature of the body rises, especially if the period of ascent is very rapid; in children chilliness is rare, but this is frequently replaced by convulsions; in the aged the reactionary phenomena are wanting, or are not marked, also febrile diseases are often unrecognized.

Alteration of the Secretions.—The secretions are diminished in quantity, because there is always deficient elimination and retention of water in the system. Salivary, gastric, biliary, enteric and urinary secretions are scanty, and so is the perspiration. We see dyspeptic symptoms accompanying these metabolic changes, because the troubles of the organs of digestion depend in a great measure on

those of their annexed glands. "Probably," says Money, "these facts explain the thirst, the dryness and furriness of the tongue, the tendency to nausea, and vomiting, and constipation; while it is easy to understand that such changes should spoil the appetite, cause the breath to be offensive, create abnormal sensations of taste in the mouth, and make an unpleasant odor arise from the cutaneous surface."

Besides the thirst, dryness, and changes noticed in the tongue, we find that the mucosities, usually carried away by the saliva, accumulate in the mouth, especially on the teeth, gums, and lips, where they assume a brownish-color, desiccate and form those fuliginosities (*sordes*) often seen in adynamic fevers, and which are principally composed of altered mucus, epithelial cells, molecular granulations, and *leptothrix buccalis*. (Alga of the mouth.)

According to Laveran and Teissier, the anorexia is due to insufficiency of the gastric juice, in the same manner as the intestinal juices and the bile, not being present in sufficient quantity to lubricate the intestines, give rise to constipation. The sweat is usually suppressed during the periods of ascent and acme, and consequently the skin is dry, more or less hot, giving at times to the hand a feeling of pungent heat. Defervescence is often accompanied by profuse sweating, as in ague, and frequently in pneumonia. The ancients considered such sweats critical phenomena, but careful, modern investigations have plainly demonstrated that defervescence always precedes the appearance of the sweat; in other words the sweat is not the cause of defervescence, but rather one of attendants of this period, when rapid, just as chilliness is one of the ordinary consequences of the abrupt ascent.

It is not rare to notice a sudden increase in the loss of weight to follow profuse perspiration, and this phenomenon usually takes place at the outset of convalescence.

The urine suffers also important quantitative and qualitative changes. Clear and abundant during *chilliness*, scanty and loaded with coloring matter during the climax, it becomes often thick and turbid during defervescence, and this because the solids (urates, etc.), which it contains in excess, are easily precipitated. But while it is susceptible to decrease to one-half of its normal quantity in 24 hours, still, as a rule, it is increased during the whole extent of the fever, probably because the patients, tormented by the thirst, take in a considerable amount of liquids. Its decrease on the other hand is explained, in part at least, by the excessive losses of water through the

skin and air-passages. The urinary secretion may also be influenced by the lowering of the tension. (Hallopeau.)

The urine of fever patients besides being of a deeper color than the normal from excess of coloring matter, is also very acid and of a very strong odor. Its specific gravity is increased, and it is very rich in potassium salts (chief mineral constituent of the tissues), and poor in chloride of sodium (chief mineral constituent of the fluids). The quantity of urates and urea may be increased or diminished, but we must bear in mind that patients are subjected to a more or less rigorous diet, and this necessarily brings about a marked diminution of the amount of urea excreted daily. Falk (*Arch. f. Exper. Path. and Pharm.*, vii.), in a dog deprived of food, noticed a fall from 54 to 19 grammes, on the second day of the fast, and to 8 grammes on the third day, consequently if this product is eliminated during fevers in proportions near the normal, we must conclude that its formation has been more active. Cl. Bernard (*Leçons sur la Chaleur de la Fièvre*, Paris, 1876,) admits that those suffering with fever excrete from 1.50 grammes to 2.89 of urea, per kilogramme, instead of 0.59 to 53; but it should be added that the febrile urine contains an excess of extractives, susceptible to be considered as albuminoid substances, which would have been eliminated, in the physiological state, under the form of urea, and which represent products of incomplete elaboration. (Hirtz). There is, however, no permanent relation between the increase of the urea excretion and the rise of temperature. In pneumonia and typhoid fever we frequently notice a diminution of the urea in spite of the persistent hyperthermia. It usually increases at the crisis, and it seems as if this product, or those from which it is derived, accumulate in the organism to be expelled *en masse* at the very cessation of the process. The increase of coloring matter and of potassium salts has been considered as the result of destruction of certain quantity of red corpuscles. (Hallopeau).

The interesting researches of Brouardel (*op. cit.*) demonstrates that the quantity of urea secreted and eliminated in 24 hours depends on two principal influences: 1, on the state of integrity or alteration of the hepatic cells; 2, on the more or less great activity of the hepatic circulation. The fatty degeneration of the liver, observed in consumptives, has as a consequence a notable diminution of the quantity of urea eliminated in 24 hours, or as it will be seen further on, the liver suffers alterations more or less profound, which very probably interfere, at certain stages of severe fevers, with the formation of urea.

Alterations of Nutrition.—As a result of excessive metabolism the body wastes and the blood becomes poor, hence emaciation and anæmia. The loss of weight varies, on the one side, with the intensity and duration of the fever, on the other, with the manner of alimentation of the patient. The latter is a subject which should engage our most careful attention. We see to-day typhoid fevers of long duration without much emaciation, and this is due to the means employed in nourishing the patient. Nevertheless it has been demonstrated that the loss of weight and consequent emaciation, induced by fever, are more considerable than those caused by an absolute diet. Wachsmuth (*Zur Lehre Von Fieber*), has observed that in pneumonia the weight of the body decreases 16 per cent. in 24 hours. In fevers we notice also alterations of the blood. In true phlegmasiæ the fibrin is markedly increased; in pyrexia, on the contrary it may be greatly diminished, and so it is that in variola and hæmorrhagic scarlatina, it hardly contains any. (Chalvet.) The researches of Andral and Gavarret and those of Becquerel and Rodier have proved that in the febrile state, the albumin and the red corpuscles are in general diminished. Modern investigations on the numerical proportion of the red corpuscles have given a new demonstration of the “*anæmiating action*” of febrile maladies. Cl. Bernard has shown that the blood of fever patients is more fluid and coagulates more slowly, and that the quantity of gas that can be extracted, is diminished. Brouardel has found in variola the carbonic acid gas reduced to more than one-third, and Légerot, Mathieu and Maljean have ascertained that, in all fevers, its capacity for the absorption of oxygen is lessened.

Among the special elements of the blood the hæmatoblasts present alterations which recently have been brought to light by Hayem (*Du Sang*, Paris, 1889.) Their number decreases during the period of acme, while at the moment of defervescence they suffer a rapid and progressive increase. We may notice their number become threefold in forty-eight hours, finding one for seven or eight red corpuscles, while the normal proportion is 1 to 18. Generally their abrupt increase takes place one or two days after the temperature has fallen. If defervescence is complete, their number reaches its maximum at the end of two or three days, decreasing then rapidly to become normal after eight or ten days. This hæmatoblastic overproduction cannot be attributed to alimentation, for it often commences when patients are still under a rigorous diet. Hayem considers it a transitory accumulation of immature elements destined to

become red corpuscles. (Hallepeau). The red corpuscles decrease likewise during the period of acme, and it is precisely at the moment of defervescence that they are less numerous. Their quantity increases the day after the hæmatoblastic issue or budding takes place, and this increase persists to the end of convalescence. By way of compensation, their wealth of hæmoglobin decreases at the very moment their number commences to increase, and they do not attain the normal standard until complete recovery. This lessening is due to the arrival of new elements incompletely developed. The white corpuscles do not present apparent modifications.

The blood of fever patients contains frequently an excess of urea and extractive principles (leucin, tyrosin, creatin, etc.), and finally we find microbes in the blood of those suffering with typhoid, paludism and anthrax, the discussion of which is out of place here.

Side by side with the alterations of the blood we should mention those of the hæmatopœtic apparatus, the lymphatic glands and the spleen being frequently found tumefied.

Parenchymatous Degenerations, etc.—In almost all acute diseases we meet with organic nutritive lesions, especially in such severe fevers as typhoid, scarlatina, variola, yellow-fever, etc. When the fever is of long duration the existence of alterations in the greater number of tissues is well-established. The muscles present a wax-like (amyloid) degeneration, first described by Zenker, in 1864, under the name of granular and waxy degeneration of muscles. This alteration, according to Lavernan and Teissier, is not peculiar of typhoid fever, as it was first thought by Zenker. It is found, say the above authorities, in a great number of febrile diseases, as variola, measles, scarlatina, acute tuberculosis, puerperal fever, etc. Its usual seat is the muscles of the trunk and of the root of the limbs, psoas-iliacus, rectus abdominis, obliquus, transversalis, diaphragm, pectoralis, intercostalis and adductors of thighs. The liver suffers frequently similar alterations; its anatomical elements become granular or granulo-fatty, and in cases where this degeneration reaches its maximum, the parenchyma is pale, dry and friable, presenting sometimes the appearance of acute yellow atrophy, but the hepatic cells are not destroyed; they are only filled up with fatty granulations, and when recovery takes place the repair is easy. This hepatic degeneration probably explains the diminished quantity of urea at the period of acme in severe fevers.

The renal epithelium undergoes also granular degeneration, allowing the escape of small quantities of albumin, hence the frequency of albuminuria in the grave febrile diseases.

But, as Hallopeau so well observes, there is no certainty that these changes are directly connected with the febrile disorder. It is possible that they are brought about by the same cause of the fever, such, for instance, as septic infection. There is not the least doubt that the fever cannot by itself produce tissue-alteration, but, up to the present time, the intimate nature of this alteration has not been determined with precision.

The fever may kill by consumption, when prolonged, by cardiac paralysis, or by hyperpyrexia.

Men, as well as the higher animals, cannot live if the temperature rises 6° or 7° above the normal, and every time that, in the course of a disease, the thermometer marks 107° , we may almost surely expect a fatal termination within a short time.

EYE AND EAR COMPLICATIONS OF EPIDEMIC INFLUENZA. *

BY WM. R. KING, M.D., WASHINGTON, D. C.

MANY pages have been written and many hours devoted to wordy discussion of this subject of *la grippe* since the first recent epidemic nearly two years ago; and which was followed by an almost, if not, quite as severe visitation the succeeding year.

The dominant school of medicine seem in this epidemic to have met their Waterloo, and confessedly are at sea regarding the best means of effecting a cure.

However, it is not my purpose here to discuss the general subject of epidemic influenza, which has already been worn quite threadbare.

Some thoughts on a few of the complications affecting the eye or ear, either occurring with or following the immediate attack, may prove of interest and should be instructive.

To this day cases are presenting for special treatment of either the eye or ear, with the history dating the inception of the malady to the time when they were attacked by *la grippe*.

The character of these manifestations are numerous and variable. Let us first take up a brief consideration of those complications affecting the eyes. I will classify them for convenience in three (3) divisions.

* Read before the Maryland State Homœopathic Medical Society at Baltimore, October 7, 1891.

1. Those of a catarrhal nature, involving the conjunctiva and the lachrymal apparatus either together or separately.

2. Cases presenting acute or sub-acute varieties of keratitis or irido-keratitis, who prior to the epidemic never had eye trouble in any way.

3. Several more or less profound conditions of disease of the tissues of the fundus of the eyes, viz., retinitis, neuritis, etc., have dated from the time when the patient was attacked by this very troublesome affection.

In many of these cases I should be tempted to put a large portion of the blame for the complications on the decidedly dangerous system of drugging resorted to by our old-school brethren. Many of these cases having been under this treatment, but almost as many came from the hands of my colleagues, and among them many of the most skilful prescribers of homœopathic remedies, consequently I am inclined to believe that they are genuine disease-complications, at least in most cases.

In the matter of the first group of cases, viz., the catarrhal, a direct involvement of the parts can readily be traced, as they occur in the cases wherein marked inflammation of the nasal passages has been present.

So direct and manifest a route of transmission, however, cannot be demonstrated in the other two groups, viz., those involving the corneal structures and iris, and those affecting the optic nerve and retina.

I am of the opinion that these latter cases are but secondarily a result of the epidemic disease, there having undoubtedly existed a previous predisposing cause, such as scrofulosis, syphilitic taint, or some severe eye-strain. The direct results of these existing conditions might have remained dormant many months, or even years, but were brought forward promptly and prominently by the epidemic malady, through its intense and characteristic enervating tendency—as we have all observed—the intense amount of physical weakness existing in our cases, without sufficient appreciable cause.

The ear as an organ of sense is subject to the same or similar predisposing conditions, latent until thrust forward by the general reduced tension of the entire system as a result of *la grippe*.

However, the majority of cases of ear-complication following or even existing during the latter part of the attack, are usually directly a result of extension of the catarrhal inflammatory process along the track of the Eustachian tubes to the middle ear, and even the mastoid cells, creating intense pain and frequently eventuating in a sharp sup-

purative condition with its attendant dangers. Undoubtedly many such cases have terminated fatally in suppurative meningitis, in localities where facilities for prompt mechanical relief were not obtainable—for, believe me, there comes a time when everything but the knife proves powerless for the relief of these cases of mastoiditis—though coming much less frequently to us, as our therapeutic armamentarium is sufficient, always excepting the necessity for the establishment of thorough drainage through the tubes by means of air inflation or application of the Eustachian bougie if necessary.

If I may be indulged a short time, I will append a few characteristic and, to me, interesting cases. That class of eye cases covered by group one, viz., the conjunctival and lachrymal exhibited little that was peculiar or characteristic, the majority running a slightly protracted course and ending in complete recovery.

CASE I.—Mr. M—, æt. about 54, in good general health. History of no trouble with the eyes until last February, when he suffered from a severe attack of epidemic influenza, accompanied, from his description of the symptoms, by an acute catarrhal conjunctivitis, particularly marked in the right eye. The inflammatory symptoms subsided; he soon noticed a tendency for the right eye to weep at all times, and eventually a tenderness and soreness developed in the inner canthus of this eye. On July 2d he presented himself in my office with an immense lachrymal abscess, swollen to fully the size of a small hen's egg, very angry and painful, pointing on the surface of the face just below the inner angle of the orbit.

The usual treatment was adopted—probing the tear duct as well as the painful condition would permit—hot applications over the swelling, etc. R. Hepar 3x, injections of sol. of pyoktanin 1 to 200 through the canaliculus.

The following day was much improved, swelling and pain greatly reduced; improvement continued slowly for three or four days, when the passages again becoming blocked, rapid and severe inflammatory action followed, and before he could reach me the abscess had opened spontaneously on the surface at the location where it had formerly pointed. The same general course of treatment was followed with improvement for seven days, suddenly followed by another abscess not so large or painful, however, as the first. Treatment was continued on the line of re-establishing the passage through the nasal duct, cleansing and antiseptic injections, etc., until now there is but a comparatively small fistulous opening, but slight swelling and no pain. Takes a No. 4 Bowman's probe fairly at present, and is in all probability going to recover completely.

CASE II.—Miss R—, æt. 17, school girl, good health apparently. Gives history of quite a severe attack of la grippe in March last; she apparently recovered all right, but she noticed that

the right eye was weak, painful at times and later the vision was slightly affected. Consulted me April 11th. I found a progressing sub-acute parenchymatous keratitis, a low grade of peri-corneal injection; lower and outer segment of cornea of right eye leucomatous and already encroaching on the portion of the cornea in front of the pupillary space. $V. = \frac{1\frac{2}{5}}{2\frac{5}{5}}$ at this time. Treatment begun by local use of pyoktanin solution 1 to 200, at my office, and a solution of nitrate of mercury 1x, 30 grains to 1 ounce, used at home four times daily. The improvement began to be noticeable in a week, and continued slowly with occasional set-backs until now; the leucoma is quite thin and transparent, and did not extend over more than half the corneal surface at any time. The present vision $= \frac{1\frac{5}{5}}{2\frac{5}{5}}$ with slight difficulty. She is going to recover full use of this eye. The remedies used were first merc. jod. flav. 3x, later kali jod. 3x for a short time (did not do well under the latter), and finally on June 29th begun ars. jod. 3x, with steady and rapid improvement from that time.

CASE III.—Miss Caroline S——, æt. 18, good general health. History of an attack of prevailing epidemic in latter part of January last, followed on recovery therefrom by weakinflamed, and troublesome eyes. She consulted one of the leading oculists of the rational (?) school of medicine, who did nothing but fit glasses and apply a collyrium, this being followed by no relief whatever. On March 16th I found what appeared to be a stubborn follicular conjunctivitis with bulbæ on the corneal edge, sticky, strong, mucous discharge, photophobia, etc. She was given a mild solution of colorless hydrastis to apply locally and *R. Kali b. 6x*.

March 18th, no improvement; eyes quite painful; photophobia marked; tested refraction, and not being pleased with the fit of her lenses, I changed them, giving her a — 0.5 cyl. axis 90°, to be worn continually. *R. Jabor. 3x* and *kali b. 6x* in alternation. Locally, pyoktanin sol. 1 to 400.

April 1st, much better, external signs of inflammation have disappeared, no congestion whatever, but complains of some deep-seated pain, sparks of fire before the eyes, particularly when in a dark room. The ophthalmoscope revealed a sharp neuro-retinitis, large patches of milk-white effusion nearly surrounding the optic disc and located in the retinal tissue, beginning atrophy of retina and choroid. I stopped local treatment and gave *phos. 6x*. This was followed, April 4th, by relief of deep-seated pains, sparks, etc., but found the surface of the eye, particularly at corneal edge, again severely inflamed, burning pain, lachrymation, etc., < in wind, etc. *R. Ars. jod.* and *phos.* alternately, and locally by tannic acid and listerine solution. April 6th, found her much >. April 13th, found small ulcer on the corneal edge, local pyoktanine sol. 10 to 200. $V. = \frac{5}{7\frac{1}{2}}$ on this occasion. April 20th, local inflammation completely subsided and ulcer healed, but now we had a resumption of the deep-seated pain and fiery photopsies. *Phos. 6x* three times daily, and strychnine 6x night and morning.

To cut a long story short, this was followed by relief of this condition only to be followed by the local inflammation and pain, but the vision was slightly stronger; these conditions continued to see-saw in this aggravating manner until finally on June 5, 1891, she complained of a dry catarrhal condition of the nasal passages and large dry, hard clinkers, which when discharged, gave her great relief.

Local detergent sprays, followed by astringent applications to nasal passages was begun, and *ars. jod.* 3x and *kali b.* 2x was given together with application of galvanic current to eye three times weekly; this was followed by immediate improvement of all conditions, until finally on July 31st. *V.* = $\frac{5}{8}$ nicely, both eyes (with lenses), no pain, no inflammation, but the atrophic spots, of course, remain at the edge of the optic disk.

CASE IV.—Mrs. R——, æt. 52, robust physique, always well. History of severe attack of epidemic influenza. During the latter stages developed a severe pain in right ear and mastoid process. Called at my office April 23d last suffering severely, pain in temporal region, mastoid process and deep in ear. Examination revealed retracted and inflamed *membrana tympani*. The treatment consisted in the application of inflation by means of the Politzer bag, local instillation of a camphorated chloral solution and dry heat locally; this was followed by some amelioration next day, but only again to break out afresh that night, when she suffered greatly. Applied chloroform and sweet oil, *5j.* to *5j.*, warm, frequently, hot dry flannels, etc. *R.* Caps. and *merc. sol.* 3x; this was followed by relief, which continued uninterruptedly, and she made a complete, though gradual, recovery, no suppuration occurring and the *membrana tympani* continuing imperforate, the hearing gradually returned under constant and careful treatment, local and therapeutic. *R.* Bell. and caps. controlled pain best, and *kali m.* assisted in restoring hearing.

CASE V.—Mrs. S. H——, æt. about 40, had been South during winter, and on her way to her home in New York stopped in Washington, only to take her bed suffering with the prevailing epidemic. When recovering was taken with severe pains deep in left ear, and temporal and mastoid region, which entirely precluded the possibility of sleep until the physician in attendance resorted to injections of morphia with only partial success in alleviating the intense suffering. April 15th I was sent for to examine and treat the ear; found her in bed suffering intense pain, threshing about and moaning, calling for morphia with every breath, pains throbbing and lancinating. Examination revealed deep-seated inflammation, interior congested and retracted, evidence of closure of Eustachian tube. After calming her I felt we could quiet the pain without resorting to morphia, but that should I fail by evening (it was then 2 o'clock P.M.) I would give her some that she might sleep.

Treatment.—Inflation thorough by means of Politzer bag, application of hot dry flannels constantly, and ordered a strong mixture of chloroform in olive oil instilled, this to be done after I left, promis-

ing to return at 7.30 P.M. When I did so I was prepared to administer the morphia should I find her still suffering. On entering her room all was still; the nurse whispered to me that she had been asleep since 3 o'clock that afternoon. I found her sleeping peacefully and naturally, pulse and respiration excellent.

As the chloroform oil had inflamed and burned the external meatus some I left a camphorated chloral solution to be used warm when she was awake and ordered flannels continued. April 16th, much better and cheerful; continued the treatment, and on the 18th dismissed the case practically well without there having been a particle of suppuration. *R.* Hepar merc. 3x and caps.

The last two cases are mentioned largely because of the success in obtaining relief in a high grade of inflammation without suppuration and consequent perforation. These are but a few of the more interesting of a number of cases falling in my hands during and succeeding the late epidemic.

If they teach us anything it is to watch the eyes and ears in la grippe, for whilst these cases here recounted terminated successfully, all have not done so by any means, and many persons stand to-day living witnesses of the fact that an epidemic of influenza has been in our midst.

CORRESPONDENCE.

THE HAHN AND VON BERGMANN SURGICAL CLINICS IN BERLIN.

EDITORS HAHNEMANNIAN MONTHLY.

As is generally well known, Berlin is in the possession of two surgical schools, each of which stands in direct opposition to the other, at least in so far as the application of modern antisepsis is concerned.

The one, namely, that of Prof. Hahn, in Friedrichshain, is known as that of "*Wet Surgery*," its leader being a firm supporter of ANTISEPSIS as advanced by Lister, while the other of Von Bergmann and his followers, known as that of "*Dry Surgery*," in contradistinction to the former, upholds A-sepsis as its cardinal principle.

It may not be out of place to mention a few of the most prominent opposing views of these two authorities before proceeding with

a brief description of their clinics. Prof. Hahn holds that *irrigation* is the first step necessary to prevent wound infection; his operating-room is therefore well supplied with appliances and solutions for this purpose. Not only, however, are the wounds thoroughly irrigated during the progress of each operation, but the whole operating-room is flooded with water after every case of a septic nature. As the assistants all wear rubber boots and aprons, and all fixtures have been purposely made to bear this treatment, no harm, of course, results to either. It is a pleasure to witness the vigor and earnestness with which Prof. Hahn attends to this matter himself.

On the other hand, Prof. von Bergmann, the *a*-septic surgeon, has discarded the *anti*-septic method almost entirely, one of the most characteristic features of his clinic being, particularly to one visiting there for the first time, a total absence of irrigating appliances, for, according to his experience, wounds are seldom infected through the medium of the air when proper cleanliness is observed in the operating-room. He therefore does *not* irrigate wounds with the various antiseptic solutions, but simply keeps them perfectly dry by means of tampons of *sterilized* gauze in the hands of the assistants.

The drainage-tube has also been relegated to a place amongst instruments of the past by him, excepting in very rare cases. In treating wounds of a tubercular or suppurating character, primary union is also sought for. To accomplish this result the wound is "packed" with either iodoform or simple *sterilized* gauze for forty-eight hours before it is finally closed by means of sutures. The results are very encouraging. It is now some three years since he has adopted this method.

The instruments are boiled ten minutes in a 1 per cent. sodium carbonate solution immediately before use, and all dressings have been previously sterilized.

As for the clinics themselves, they are both exceptionally well arranged, light, ventilation and good drainage having been well kept in view throughout their entire construction. Finally, it may be well to mention that both clinics, though in different sections of the city, occupy entirely separate buildings from the others of their respective hospitals.

J. F. RAUE, M.D.

BERLIN, 1891.

CHICAGO, December 4, 1891.

EDITORS HAHNEMANNIAN MONTHLY.

Gentlemen : In your last issue of the HAHNEMANNIAN MONTHLY, Dr. Van Baun, in a paper on "Climate for Consumptives," makes, on page 847, a curious error. "Sanford," he says, "on Lake Monroe, is one of the highest points in the State, the air is dry, salt and rich in ozone."

A similar statement appeared in the *Medical Record*, and in answer to my note, the author of the paper stated that he got his information from a physician in Sanford. Now, the fact is, that the whole statement is erroneous and should be corrected.

Sanford is not more than 18 feet above sea-level, and not more than 8 feet above the level of Lake Monroe at high water. The air is *not* dry ; on the contrary, very damp. It is not salt, for it is 30 miles from the sea. Nor do I believe there is any special exuberance of ozone there. For miles in all directions the land is "*flat pine*," with frequent swamps and bogs. The highest land in Florida is not more than 450 feet above sea-level, and that land is on the west coast, 75 miles from Sanford. On the opposite shore of the lake from Sanford the land rises 80 feet above the lake, but that is 4 miles away.

E. M. HALE, M.D.

Sanford is located at the extreme northern border of Orange Co., Fla., on the south shore of Lake Monroe, in latitude $28^{\circ} 47'$, longitude $81^{\circ} 15'$. Elevation above tide-water, 22 feet. Population, 3200. It is the terminus of the Jacksonville daily steamboat line on the St. John's river. Its climate is superior to many portions of the State, but it is vastly inferior to that of the western or gulf coast. As a health resort for incipient consumptives or for convalescents generally, Tarpon Springs is immeasurably superior.—EDS.

ATROPINE SULPHATE IN TETANUS.—Count Werner von der Recke-Volkmerstein, senior, has used atropine sulphate 2c., with success in tetanus. Ten globules of the second centesimal attenuation of the sulphate of atropine are poured into a cup of warm water and dissolved. Of this one teaspoonful may be given every ten minutes. If the jaws are locked a teaspoonful may be poured in between the cheek and teeth ; yet it is most certain to give a hypodermatic injection into the nape of the neck—of the second centesimal attenuation.—*Homöopathische Monatsblätter*, No. 11, 1891.

EDITORIAL.

DR. THOMAS'S ANNOUNCEMENT.

It was with great regret that we read the notice, received as we went to press last month, announcing that Dr. Charles M. Thomas has retired from the practice of general surgery and will hereafter confine himself to diseases of the eye and ear.

Conversation and correspondence with physicians, not only in the vicinity of Philadelphia, but the country over, shows how highly Dr. Thomas's work as a surgical teacher, writer, consultant and operator is appreciated and how much he will be missed in a field in which industrious and brilliant men are so greatly in demand.

It is particularly in Philadelphia and in the Hahnemann College that Dr. Thomas's career has been felt. Returning from Europe at a time when our school might be said to have had no specialists, he was obliged for years to do duty as an almost universal specialist, and this with no one on whom he could lean for counsel or support. It is largely through his teaching, example and encouragement that there have grown up around him a group of men who have done such excellent work in their several specialties and of whom he, more than any one else, has reason to be justly proud.

We are glad to say that it is not on account of any failure in health or any waning of intellectual or bodily activity that Dr. Thomas is led to give up part of his work, but because of his inability to do justice, conscientiously, to all of it. For years eye and ear practice, general surgery, surgical and eye and ear teaching and hospital duties were constantly crowding and interfering with each other. First didactic surgical teaching was laid aside, then clinical surgery and, lastly, eye and ear teaching, both didactic and clinical. Even then general surgery and eye and ear work interfered with each other so much that Dr. Thomas felt compelled to take the step he has announced.

Hahnemann College and its classes are to be congratulated on regaining a teacher so popular and valuable; Hahnemann Hospital will again come in for his services; but we predict that within a year the Doctor will be as overrun with eye and ear surgery alone, as he was when he gave up general surgery, and that he will continue to do, as heretofore, the work of two men. We sincerely hope he will long be spared to the profession that so highly esteems him.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D.,

With the Collaboration of

FRANK H. PRITCHARD, M.D., AND EDWARD M. GRAMM, M.D.

PLEURITIS DURING THE ERUPTIVE STAGE OF SYPHILIS.—Drs. Chantemesse and Vidal have observed two cases in women, which presented pleuritis with exudates, at the same time that the eruption appeared, and could not explain it otherwise than that the pathogenic agent had localized itself on a serous membrane. Joint pains have been observed during the rise of temperature accompanying the outbreak of the secondary symptoms. This form of pleurisy should not be confused with that of tertiary syphilis, which has been recently described by Dienlafoy. The first patient was a 29-year-old woman, who entered with papulous syphilides. Her throat was affected. She complained of sleeplessness and pains in the joints. Appearance was miserable. Temperature, 39° C. Four months before she had had the characteristic eruption of roseola. Two months after, pleuritis of the right side appeared, and one month after that the opposite side was attacked. Physical examination revealed an exudation at each pleural cavity, with dulness in the lower portion of the posterior portion of the thorax. The joints were somewhat sensitive on pressure, hence a rheumatic pleuritis was suspected. Towards the end of the fourth month of the disease iritis appeared, pleurisy still being present. Temperature between 38° and 39° C. Inunctions with mercurial ointment were ordered, when the syphilitic cutaneous phenomena and pleuritic exudates disappeared.

The second patient was a 45-year-old woman, who entered the hospital about one month after the disease first broke out. She had fever, was asthenic, complained of sleeplessness, headache, pains in the muscles and joints. Roseola all over her body, throat affected. All these symptoms continued until the fourth of the next month. The temperature kept at 39° C. The patient was quite prostrated. Physical examination demonstrated the presence of a pleuritis sicca of the base of the left lung. No cough. Inunctions with unguentum cinereum, together with internal use of iodide of potash, were instituted. The temperature sank in a short time, the exanthem disappeared, together with the pleuritis and the patient was discharged cured, four months after the outbreak of the disease. In the former case the disease might have been ascribed to another cause than syphilis. But secondary syphilis attacks all organs and tissues, and why should the pleura be exempt? The patient presented signs of no other disease than syphilis. In the second case there can be no doubt as to the connection, as the pleuritis followed closely the course and development of the other syphilitic phenomena. Finally, anti-syphilitic treatment was successful in both cases. Dr. Duponcel stated that he has several times observed peri- and endo-carditis appear during the course of primary and secondary syphilis.—*Norsk Magazin for Sægevidenskaben*, No. 6, 1891.

THE SWEAT IN TUBERCULOSIS PULMONUM.—1. A phthisical patient perspires profusely at a high or a moderate temperature. 2. The sweats appear mostly when the patient sleeps, whether in daytime or at night. 3. There is no other disease in which perspiration is so profuse and so constant. 4. Perspiration increases towards the end of the disease. 5. It is most copious in acute cases running a rapid course. 6. It accompanies the chronic as well as the acute, miliary, disseminated tuberculosis, especially in the strongly remittent form. 7. After sweating the patient feels perfectly exhausted, which distinguishes it from a critical sweat, which relieves when the skin is warm, and the sweat soon dries up. 8. During the sweat of tuberculosis the skin is cool, pale, and the sweat remains long on the body. 9. The sweats appear at an early stage of the disease. 10. Sweat appears in large quantity. 11. It is often preceded by restlessness, high fever, palpitations, etc. 12. We

do not know how it differs chemically from other sweats, as it is well known that the sweats of phthical patients are not caused by bodily exertions, retention of urine, crises, increased circulation of the blood in the skin, increased blood-pressure, etc. We must look for its cause in the essence of tuberculosis, and explain it by transitory palsies of the vasomotor cutaneous nerves, arising from the irritation produced by the products of the bacilli tuberculosi accumulating in the blood, whereby the organism tries to expel the ptomaines by sweating.—*Wien. Med. Presse*, 17, 1891.

DIAGNOSIS OF CARCINOMA OF THE CARDIAC END OF THE STOMACH.—Dr. Lanenstein, of Hamburg, has observed in two cases of carcinoma of the cardiac end of the stomach, confirmed by necropsy, the presence of a loud, systolic sound in the epigastrium immediately under the arch of the ribs, with isochronous radial and femoral pulse and normal heart-sounds. Therefore in cases where a stenosis of the œsophagus 38 to 41 centimetres behind the teeth is found on introducing the œsophageal sound, he advises one to auscultate the aorta in the epigastric region immediately under the ribs.—*Wiener Med. Presse*, No. 40, 1891.

PSEUDO-TUBERCULOSIS, OR ZOOGLOEIC TUBERCULOSIS.—Dr. Guiseppe Zagari, of Naples, Italy, has experimented with micro-organisms taken from apparently tuberculous nodes in guinea pigs, inoculated cultures and raised micro-organisms, which, injected into other guinea-pigs reproduce the same disease. Each node, on microscopic examination, showed itself to be composed of small, round cells, and passed, without distinct margins, into the surrounding normal tissue. Older granulomata presented an epitheloid appearance, with signs of hyaline degeneration in the nodes and surrounding tissue. The centre of each contained a cheesy and granular mass, which microscopic examination showed to consist of micro-organisms. Malassez and Vignel, in 1883, described under the name of zoogloëic tuberculosis a disease entirely resembling tuberculosis with a micro-organism which was not, however, Koch's bacillus. Eberta later described a pseudo-tuberculosis in rabbits.—*Norsk Magazin for Sægevidenskaben*, No. 10, 1891. Prof. Hayom, of Paris, France, isolated and cultivated the bacillus of pseudo-tuberculosis from a case of Addison's disease with tuberculosis of the suprarenal capsules. Dr. Chantemesse claims to have isolated the bacillus of pseudo-tuberculosis some years ago. He regards this disease as by no means so rare in man as is generally held.—*Bulletin Medical*, No. 56, 1891.

BACILLARY INTERSTITIAL NEPHRITIS.—Dr. S. Setzerich has observed forty-five cases of this disease in ten years. These cases have chiefly been those of children, and, rarely, young persons of 14 to 22 years of age. The disease, as a rule, appears endemically, sometimes sporadically, and with the same symptoms as an ordinary case of acute nephritis. It leads, with few exceptions, to recovery, and has an acute course. In two or three cases it became more chronic, but seemed never to go over into actual chronic nephritis. The urine of the patients contained small, thick, straight and bent bacilli, rarely filiform, and spores which were all easily colored with the aniline coloring materials. These were regarded by the writer as the cause of the disease. These bacilli were also found in the foci, in the kidneys, especially on the borders of the cortical and medullary substances. Inoculated into gelatine they quickly liquefied it, and in rabbits they produced a primary interstitial nephritis.—*Zeitschrift für Klin. Medicin*, p. 528, 1891.

GANGRENE FOLLOWING VACCINATION IN A CASE OF MALIGNANT SYPHILIS.—Balzer presented a patient to the French Society of Dermatologists and Syphilographers, who came under treatment for chancre October 14, 1889. She had a hereditary tendency to phthisis, and was very weakly. In a short time classical manifestations of syphilis appeared, the skin symptoms being specially severe, with tendency to marked ulcerative lesions. She was vaccinated on the 20th, three places being vaccinated, of which one took. At first normal development of the vaccine pustule occurred, to be soon followed by rather extensive infiltration of the surrounding connective tissue and gangrenous casting off of the affected parts. The line of demarcation commenced to form about two months later, complete healing resulting February 14th. In the discussion following the presentation of this case Mauriac called attention to the peculiar tendency to ulceration and gangrene that slight injuries have in syphilitics.—*Archiv. für Dermatologie und Syphilis*, Heft 5, 1891.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

DIAGNOSIS OF AND OPERATION FOR STONE IN THE KIDNEY.—Israel reports the case of a man, forty-one years of age, who had suffered, on and off, for years from pain in the left renal region, which increased in severity with each attack. At times there was hæmaturia, but the urine was usually clear when voided, and after standing for a time, a slight cloud formed, which contained blood cells. Physical examination revealed marked tenderness over the left kidney. A lumbar incision was made parallel to the twelfth rib, down to the kidney. Palpation proving negative, the organ was freed from the surrounding fat and again examined by the fingers. This also failing, punctures were made in several directions, with no better result. The operator, feeling certain of his diagnosis, as a last resort incised the kidney through its convex border, opening the pelvis. On introducing the finger a calculus was found, which was readily extracted by means of forceps. The somewhat profuse hæmorrhage was controlled by tamponading, after which the kidney wound was closed by deep sutures. The patient made an uninterrupted recovery. The above result is seldom seen, owing principally to the difficulty in making a positive diagnosis, the only pathognomonic sign being to feel the stone, which is rarely possible. The other symptoms, and those most frequently present—such as renal colic—being caused by various other conditions: large quantities of uric acid or oxalate of lime crystals in the urine; pyelitis, with the formation of a large amount of triple phosphates. Spondylitis may also be a cause of colic, which may be present, too, in hydro-nephrotic conditions. Diminished quantity of urine, with frequent desire to urinate during the attack, is often found in renal lithiasis, but may also be wanting. The tenderness on pressure during an attack is alike inconstant. Probably one of the most characteristic signs of stone is the constant presence of blood-cells in otherwise normal urine. The author advocates exploratory lumbar incision in cases where one is reasonably certain. If exposing the convex surface of the kidney does not suffice, the organ is freed so that it can be palpated between the fingers. Should this prove insufficient, punctures are made, and lastly, as in the case just described, incision. This is made through the substance of the kidney, as wounds of the pelvis do not heal kindly and are apt to result in a permanent fistula. Although incision through the substance has the disadvantage of being accompanied by considerable bleeding, this can be controlled by tamponading or suture.—*Centralblatt für Chirurgie.*

COMBINED USE OF IODINE AND ELECTRICITY.—Hunter McGuire has met with several cases which tend to show that the combination of these well known absorptive agents acts more efficiently than either one alone.

1. *Goitre.*—In a case of old, large, hard, bilateral thyroid enlargement with marked dyspnoea, which had resisted all ordinary treatment, the following procedure was successfully employed: A cup-shaped electrode was filled with cotton; this had been dipped in water and squeezed as dry as possible; ten or fifteen drops of the tincture of iodine were poured on the cotton. The electrode was applied to the most prominent part of the tumor, the negative pole being placed on the back of the neck, and the galvanic current turned on until the milliampere-meter registered six to eight. The current was kept up for ten minutes, and, when removed, it was found that most of the iodine had disappeared from the cotton. During and after the administration there was usually a marked taste of iodine in the mouth, this being the most disagreeable feature of the treatment. This was repeated every day for three weeks, the tumor decreasing very rapidly in size at first, but slowly afterward and becoming more indurated as it contracted. After a month's absence the same treatment was renewed. The tumor was reduced to one fifth of its original size, after which it remained persistently stationary. The general health was much improved, however, and all subjective symptoms disappeared. Two other cases of chronic goitre, treated in the same way, have given similar results. In four cases of recent enlargement of the thyroid in young women, the growth rapidly disappeared under this treatment. In a recent case of exophthalmic goitre, iodine combined with the galvanic current, induced rapid diminution of the thyroid tumor, which was accompanied by a decided amelioration of the tendency to syncope and the pulsation of the arteries. The ocular protrusion, however, remained stationary.

2. *Chronic Inflammatory Enlargements.*—In several such cases, notably one of chronic orchitis, this measure was used with positive benefit.

3. *Uterine Fibroids.*—The writer expresses his belief in the treatment as suggested by Apostoli. When the tumor can be reached through the vagina, the combined iodine and galvanic treatment, with a current of ten milliamperes only, has done good and that without pain. The bleeding has ceased and the pain has disappeared.

The author proposes to apply the same principle to tonsillar hypertrophy and has had an electrode constructed for the purpose; he suggests that other medicated fluids may be applied in the same way.—*Virginia Medical Monthly.*

SPERMATO-CYSTITIS.—Jordan Lloyd considers inflammation of the seminal vesicles a much more common disorder than is generally thought and taught, the symptoms being usually referred to prostatic disease, just as tubal lesions a few years ago were overlooked or considered indications of uterine trouble. From an anatomical standpoint it seems reasonable to suppose that spermato-cystitis will occur more frequently than epididymitis; the common ejaculatory duct runs back through the prostate for about three-quarters of an inch and then divides into the duct going to the seminal vesicle, which is not over half an inch in length, and the vas deferens, going to the epididymis, which is fully sixteen or eighteen inches long. Like epididymitis, spermato-cystitis is rarely a primary malady, but is almost always secondary to urethritis. They both occur during the third or fourth week of gonorrhoea, and affect chiefly the connective tissue lying between the tubular structures, giving rise to a brawny swelling, which, felt in the anterior wall of the rectum, is mistaken for an inflamed prostate. Suppuration is a rare complication in epididymitis, and, when it occurs, will give rise to a deep-seated abscess, which may open into the rectum, urethra, bladder, or even into the peritonæum. Spermato-cystitis may be acute, sub-acute or chronic, and the symptoms are those attributed to prostatitis, inflammation of the neck of the bladder, or vesical irritability. A correct diagnosis can only be made by careful rectal palpation. The swelling, which varies in degree according to the severity, will be found to occupy the whole base of the bladder, from side to side, and to extend beyond the reach of the finger. In the chronic form the enlarged vesicle can be made out. It is more than probable that most attacks of so-called gonorrhœal prostatitis are in reality spermato-cystitis, for there seems to be no more reason for involvement of prostatic tissue than of the corpus spongiosum or bladder wall; but an inflammation that so often spreads along the ejaculatory duct and the vas deferens to the epididymis can readily find its way to the seminal vesicle.—*London Lancet.*

SUTURE IN CLOSED FRACTURES OF THE CLAVICLE.—Poirrier revives the procedure of Langenbuch and reports a case of simple, comminuted fracture of the left clavicle, which he incised, removed a splinter, and united the two main fragments with silver wire. Such an operation should be undertaken under the following circumstances:

1. When, owing to severe subcutaneous injury of the vessels and nerves, it is necessary to make an incision in order to arrest hæmorrhage or search for a divided nerve. The broken ends of the bone, which are thus exposed, may be sutured without increasing the risk.

2. Cases of comminuted fracture with one or more displaced fragments, which, later on, may give rise to trouble in the brachial plexus, or to the formation of a large and irregular mass of callus, in which the nerve trunks may be involved.

3. When there is much overriding of one of the fragments. In such cases shortening usually results, which is objectionable from a cosmetic standpoint, as well as from the fact, proved by experience, that such a condition interferes with the usefulness of the arm.

4. When both clavicles are fractured, the respiratory disturbance caused by the weight of both shoulders and arms is relieved, and permanent consolidation is hastened by wiring.—*Semaine Médicale.*

REMOVAL OF CARIOUS BONE BY HYDROCHLORIC ACID AND PEPSIN.—Robert T. Morris reports, as the result of experiments, that a two or three per cent. solution of hydrochloric acid can be safely used to decalcify carious or necrotic bone in adults or children. It should be used in alternation with pepsin, the latter digesting the organic matter and clearing the bone for the further action of the acid.—*Medical Record.*

TRAUMATIC RUPTURE OF THE SMALL INTESTINE.—Jahoda reports two such cases successfully treated by laparotomy. The symptoms of obstruction followed a blow on the abdomen. A brownish fluid was found in the peritoneal cavity, and the intestines were agglutinated by a fibrino-purulent exudate. A perforation in the small intestine, at a point opposite the mesenteric attachment, was present in each instance. These were closed and the abdomen cleaned and irrigated with salicylic acid solution. The operation was performed twenty-five and eighty hours respectively after the injury.—*Wiener Medizinische Presse*.

INTESTINAL PERFORATION IN TYPHOID FEVER.—In a paper read before the Association of American Physicians, Fitz states that this complication occurs in about one per cent. of all cases of typhoid fever, and is the cause of death in about six per cent. of all fatal cases. It occurs twice as frequently in males as in females, and is very rare in children; it takes place in the small intestine in four-fifths of all cases, in mild and severe attacks, and produces symptoms which may be latent, mild, gradual, or severe. It is probable that the appendix is more often inflamed and perforated in typhoid fever than has hitherto been suspected, and these cases are more likely to recover than those in which other portions of the bowel are perforated. Of ten cases in which early laparotomy has been resorted to, but one recovered, while of twenty-seven patients with circumscribed peritonitis, in typhoid fever, presumably due to intestinal perforation, three recovered after incision, seventeen after resolution, and seven after the spontaneous discharge of pus. Immediate laparotomy should be employed for cases of suspected perforation in mild cases only. In all other cases the evidences of a circumscribed peritonitis should be awaited, and may be expected in a few days. This condition can then be relieved by operation as soon as the patient's strength permits.—*New York Medical Journal*.

RECURRENCE OF CARCINOMA OF THE BREAST.—Dennis considers that this is influenced:

1. By the period of time from the appearance of the growth to the date of the operation. The time of election is within six months from the first appearance
2. By the extent to which infiltration had taken place by one or more of the three generally recognized ways of dissemination.
3. By the radical character of the operation, *i.e.*, one including the entire gland, all neighboring fatty and areolar tissue, all overlying integument, and as much more as necessary, the pectoral fascia, and the axillary contents, glandular and fatty.
4. By the histological character of the carcinoma, soft growths infiltrating and producing metastases much more rapidly.
5. By the simultaneous appearance of carcinoma in both breasts, when secondary deposits occur very early.
6. By personal factors, such as age, sex, marriage, fecundity, sterility, traumatism, heredity, menstruation, mental condition, locality, nativity, race, etc. With early and radical operations, the recurrences of carcinoma of the breast, after removal, will be of comparatively rare occurrence. The writer also refers to the *nitric acid method for detecting carcinomatous tissue*, recently recommended by H. J. Stiles, of Edinburgh. It is carried out as follows: 1. Immediately after removing the breast, it is thoroughly washed to remove all traces of blood. If this is not done, the blood is blackened by the action of the acid, is removed with difficulty, and obscures the appearances to be looked for. 2. The tumor is soaked for about ten minutes in a five per cent. aqueous solution of nitric acid (B. P.). 3. It is washed in running water five minutes, and, 4, placed in undiluted, methylated spirit for two or three minutes. This can be done while the axilla is being cleaned out. 5. The cut surface is then examined to determine whether any portion of the tumor or any disseminated cancer foci, or any mammary tissue are exposed. In two cases a cancerous speck, no larger than a pin's head, was demonstrated, the corresponding portion of the wound searched, and the remainder of the disease discovered and removed. The accuracy of the test was, in each instance, corroborated by microscopic examination. The same method will also, materially aid the microscopist in selecting the cancerous portions of a specimen for sections. The effect of the application of the nitric acid solution is to render all carcinomatous tissue and parenchyma dull and opaque white, from coagulation of the albumin of the protoplasm of the cancer and epithelial cells. The fibrous tissue of the stroma is rendered gelatinous, translucent, and homogeneous in appearance,

and somewhat India-rubber-like in consistence. The fat is unaltered. It should be borne in mind that the portions selected for microscopic examination must not be allowed to remain in the acid solution for more than a few minutes, as the tissue will be rendered too hard for section cutting.—*New York Medical Journal*.

RUPTURE OF THE BLADDER.—Cabot advises that when an intra-peritoneal vesical perforation is made out, the abdomen be at once opened, the bladder wound sutured, and the organ drained. Even when there is a reasonable doubt as to whether the rupture is intra-peritoneal or not, an immediate laparotomy should be done. On the other hand, if the rupture is diagnosed as extra-peritoneal, but it is uncertain in which direction the urine is extravasated, an exploratory abdominal section should be made, with a view of ascertaining how the drainage should be made. In fractures of the pelvis, when it is evident that urine has escaped into the prævesical space, a suprapubic incision should be made, to thoroughly drain the effusion, a perineal, median, or lateral section serving a like purpose for the bladder. When a long operation cannot be borne on account of severe shock, a median perineal section can be quickly made for drainage, and utilized for exploration to locate the position of the rent. The information thus obtained will serve as a guide for further interference in case the patient rallies.—*Boston Medical and Surgical Journal*.

CORROSIVE SUBLIMATE BATHS IN COMPOUND FRACTURES INVOLVING JOINTS.—Mausee Moullin recommends the following treatment in the above cases: The injured part is completely immersed in a bath of corrosive sublimate solution at the temperature of the body. If the injury is a recent one, and the wound clean, a 1 to 10,000 solution is used, to which a few drops of muriatic acid are added, and the part is immersed for two hours, night and morning. If the injured part is foul, some time has elapsed since the injury, or inflammation has already set in, the submersion should be continuous for forty-eight hours, a 1 to 1000 solution being used for the first two hours. A number of *primary* and *secondary* cases were successfully treated by this method. The advantages claimed are that decomposition is prevented; the limb is evenly supported on all sides, so that there can be no tension or pressure; there is no muscular spasm to cause displacement; prolonged and repeated cleansing of the wound is unnecessary; the question of the vitality of crushed tissues is eliminated. They are placed in the best possible position for recovery if any vitality is left, and, if dead, decomposition is prevented, and they can do no harm. A simple wooden splint is of use to facilitate lifting the limb in and out of the bath; between immersions the injured part is done up in gauze, wood-wool, or lint. Toxic symptoms are not to be feared, unless the immersion is kept up for much longer periods. This is probably due to the insoluble coagulum of lymph, produced by the bichloride. This treatment should be limited to cases in which there is a doubt as to the vitality of the tissues and as to whether amputation will be necessary. The wound looks badly, and the granulations are cedematous, after these immersions, and subsequent healing is very slow. When there seems to be a reasonable prospect of primary union, the bath should not be used.—*London Lancet*.

TREPINE OPENINGS CLOSED BY CELLULOID PLATES.—Billroth and Fillenbaum report the successful use of celluloid plates to close trephine openings in cranial fractures. The wounds healed kindly. In traumatic epilepsy this method has not been successful.—*Wiener Medizinische Presse*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

VULVO-VAGINITIS OF YOUNG CHILDREN.—Dr. Comby finds the vulvo-vaginitis of young children quite common among the poorer classes, where they are compelled to live huddled together. It is rare, yet possible in the new-born and infants, generally appearing when the children begin to sleep with their sisters and mother. Of 151 cases observed by the writer, 84 were over 2 and less than 10 years of age,

is certainly contagious, but rarely gonorrhœic in its origin, as it is derived from vaginal discharges not capable of producing gonorrhœa, but ophthalmia and vulvo-vaginitis in children. Many healthy women who were incapable of transmitting gonorrhœa to their husbands have given either ophthalmia or vulvo-vaginitis to their young (female) children. Side by side with this disease one must place the aphthous-vulvitis of Parrot, the vulvitis which accompanies some eruptive disease, as varicella, impetigo, etc., the chronic leucorrhœa of anæmic and scrofulous females, traumatic and irritative vulvitis from oxyuris vermicularis, masturbation or defloration. These latter are easily managed and non-specific; the first is often tenacious and subject to recurrence and relapses. If the vulva alone be attacked the treatment is easy; if the vagina be invaded it is more difficult. In treating it the writer recommends: local antiseptics as sulphur baths, washing twice daily with a corrosive sublimate solution, 1 to 2000, or of boric acid, 4 per cent.; then salol on a tampon of absorbent cotton. If vaginitis be also present he uses vaginal suppositories of salol, which must be very small so as to be able to be introduced into the vagina.—*La Riforma Medica*, No. 177, 1891.

REFLEX IRRITATIONS AND NEUROSES CAUSED BY STRICTURES OF THE URETHRA IN WOMEN.—In a paper read before the American Society of Andrology and Syphilology, Dr. Fessenden N. Otis said that stricture of the urethra in the female has been so rarely considered or even referred to in works on the general diseases of females, or in the special diseases of the genito-urinary organs in the female, that it might hence be inferred to be a difficulty so rare or so unimportant as to be of little practical consequence. Symptoms in the female which in the male would be at once accepted as indicating the probable presence of urethral stricture, are often referred to under the title of "irritable bladder," and attributed to causes quite independent of their possible relations to the urethra. The fact that stricture of the male urethra is accepted as usually due to gonorrhœal inflammation or some traumatic cause, while the "irritable bladder" in the female occurs quite independently of any previous recognized inflammation or injury, tends doubtless to prevent the consideration of stricture as a possible cause of the trouble. In regard to the origin of organic urethral stricture, either in the male or in the female, the author was thoroughly convinced that the foundation of at least the largest proportion consisted of cicatricial deposits due to lithiasis at periods often long antecedent to the gonorrhœa to which they were attributed. Dr. Otis then gave the histories of four cases of stricture of the urethra in the female, causing reflex disturbances as varied and as severe as those occasionally caused by strictures of the urethra in the male. These patients were relieved by removal of the strictures. The author suggested the desirability of early exploration of the urethra by means of the urethrometer or the bulbous sound, in order to promptly eliminate at least one important cause of failure in the diagnosis and treatment of such cases.—*Journal of Cutaneous and Genito-Urinary Diseases*, November, 1891.

DIAGNOSIS OF ACCIDENTAL HÆMORRHAGE occurring during the first stage of labor at full term is possible at its inception by careful attention to the initial phenomena. The labor pains are irregular and feeble. Sometimes they are strong and then die away. There is a continuous pain in the lower part of the abdomen which gradually increases until it assumes a bursting character. External bleeding is absent in three-fourths of the cases reported. As Dr. Goodell says, it should be regarded as confirmation of the diagnosis already made. The pulse and general appearance now indicate internal hæmorrhage; the labor is entirely arrested, she grows weaker, collapses, and may die at any moment; or after rupture of the membranes, strong pains may appear, and she may be delivered but to succumb to post-partum hæmorrhage or shock.—Dr. Henry C. Coe, *Annals of Gynecology and Pediatrics*, October, 1891.

HIGH AMPUTATION FOR CANCER OF THE CERVIX UTERI.—After reporting two series of cases which had undergone the radical operation, Dr. Wm. H. Baker draws the following conclusions:

1. That a thorough removal of all the disease should first be made with the scissors, scalpel or uterotomy, keeping well outside the infiltration, and in apparently healthy tissue.
2. That the wound should not be immediately closed, but that every portion of it should be kept under observation until entirely healed.

3. That the thorough application of the cauterly is an all-important factor in the success of the operation.

4. That it is often necessary to do some slight secondary operation to insure success.

5. That the cases must be under close observation for years.—*Annals of Gynecology and Pædiatry*, October, 1891.

In ninety cases out of a hundred, malignant disease somewhere in the genital tract will be found to be the cause of hæmorrhage occurring after menstruation has entirely ceased, but occasionally this recurrence of hæmorrhage, when apparently due to cancer, is really due to hæmorrhagic vaginitis.—T. G. Thomas, M.D., *Archives of Gynecology*.

DR. ROBERT BARNES concedes that albuminuria caused by pressure of tumor is not usually so serious as in pregnancy, but observed that if the condition were allowed to persist, the result was confirmed Bright's disease.—*Archives of Gynecology*.

EXAMINING specimens from cases operated upon for hæmato-salpinx, Dr. H. Walter found structures which bore a certain resemblance to chronic villi. He believed them to be shreds of structureless membrane with dark borders—mere fragments of fibrin, in fact. Dr. Walter holds that tubal gestation cannot be diagnosed with certainty, unless at least decidual cells are present.—*Archives of Gynecology*.

TRENDELENBERG'S FLEXIBLE DRESSING.—Prof. Trendelenberg has been using at his clinic a gelatin paste, recommended by Unna, that is designed to be substituted in those cases where flexible colodion or india-rubber solution have formerly been employed. It will hold dressings in place while permitting free motion of the parts. It is not friable nor very stiff, and is not so adherent to the cuticle as to interfere with the excretory functions of the skin. It therefore does not cause the peeling off of the upper layers of the epidermis upon being removed, and the tendency to eczema in consequence. The thick paste contains gelatin, glycerin, and water, each thirty parts, with oxide of zinc, ten parts. The thin paste has gelatin twenty parts, glycerin thirty parts, water forty, with oxide of zinc, ten parts. Heat is necessary when the pastes are compounded; it is also needed to liquefy them when used. The pastes are readily removed with warm water.—*Archives of Gynecology*.

INDIGO AS AN EMMENAGOGUE.—At a meeting of the Tennessee State Medical Society, Dr. Jones related his experience with indigo as an emmenagogue. He has tried it in many cases. His first case was a young lady, aged twenty, who had not menstruated for five months. After three months' treatment with the usual remedies, he ordered indigo ζ ij, subnitrate of bismuth ζ ss, well mixed. Of this, the patient took one-half-teaspoonful in one-third of a glass of water, three times daily, for nearly four weeks, when one day he was sent for in great haste. While walking, the patient had, without pain or warning, began to flow. She has not suffered from amenorrhœa since.—*Archives of Gynecology*.

NAUSEA AND VOMITING may be relieved, it is claimed, by a mixture of one part menthol, twenty parts alcohol, and thirty parts simple syrup given in teaspoonful doses every hour.—*Archives of Gynecology*.

MENTHOL IN HYPEREMESIS GRAVIDARUM.—Dr. Gottschalls used this drug in a severe case. All treatment proved unavailing till menthol was given in the course of the thirteenth week. The prescription was: Menthol, one part, spirit vin., twenty parts, aq. dist., one hundred and fifty parts; one table-spoonful of the mixture every hour. Relief was almost immediate. The vomiting did not return and the patient was soon able to return to work.—*Archives of Gynecology*.

HYDRO-SALPINX has generally associated with it a disseminated cystic degeneration of the ovary, which, taken with the condition of the tube, forbids the hope of a restoration of the functions of the organs, save in such an imperfect manner as to render it rather a curse than a blessing.—W. M. Polk, M.D., *American Journal of Obstetrics*.

A COMBINATION of stretching the perinæum just before the head passes, with support during the final stage is strongly advocated by Dr. Pearse.—*Archives of Gynecology*.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

THE REMOVAL OF THE CRYSTALLINE LENS IN HIGH DEGREES OF MYOPIA.—The originator of this ingenious device, by means of which a dangerous myopic eye can be changed into a comparatively harmless hyperopic eye, is not known, but Dr. Fulkala, of Pilsen-Karlsbad, has, within the past few years, experimented on some nineteen cases, which he recites in Von Graefe's *Archiv. für Ophthalmologie*. In these cases he clearly demonstrates that good results have been obtained in many cases, the improvement ranging in many from four-fold to twelve-fold, with a medium or average improvement of seven-fold.

Myopia is necessarily a progressive trouble of the eye, and the more the eyes are used the faster is the increase of the error. The fundus in most cases is very characteristic: there is usually a thinning of the choroid, and this thinning may be so great as to cause the diagnostic rupture at the nerve entrance, viz., the myopic crescent. Again, there may be patches of choroiditis, and even choroidal atrophy in the fundus; when this is the case, operative measures are contra-indicated.

The lens may be removed when there is a myopia above 13 diopres; when the patient is not over 25 or 30 years old, and is able to read No. 1 of Targer's test-types as his punctum remotum; when, on further examination of the fundus of such an eye, the retina, choroid and nerve are found healthy and free from all inflammation or results of inflammatory processes.

How should the lens be removed? Dr. Fulkala recommends in all cases an iridectomy upwards, lessening thus the danger from intra-ocular tension consequent upon the discission of the lens, the iridectomy also preventing any occurrence of iritis or choroiditis. The lens should be removed by discission and not by extraction—secondary cataract should always be guarded against.

The advantages resulting from the aphakia are summed up briefly: 1. Distinct vision for the eye is obtained. 2. Retinal images are very much enlarged, which in itself is a marked benefit. 3. Visual acuity is improved. 4. When using the eyes normally for distance the myope uses his accommodation, thus the relaxation of the accommodation is marked and complete in many cases, the accommodation being impaired, which latter condition cannot be called strictly an improvement, yet it is an advantage when compared with the previous condition present in the eye prior to the operation. Often in high degrees of myopia the binocular vision is at fault, especially when the myopia in the two eyes is far apart as to degree. Binocular vision for near work is restored by this removal of the lens. 6. The work at the punctum proximum is held at proper distance from the eyes and not at the myopic distance, which varies with the degree of refractive error. 7. Spasms of the accommodation and all disturbing elements disappear from this method of treatment. 8. The myopia is converted into a hyperopia, which is not progressive and ceases to be an annoyance as soon as the eyes are properly adjusted with glasses.

SPRING CATARRH.—Coüeteux draws attention to the connection between spring catarrh and naso-pharyngeal disease. Trousseau also supports the views set forth by Coüeteux, and states that spring catarrh may arise secondarily to disease of the nasal and pharyngeal mucous membrane.

Spring catarrh appears to be frequently met with in the neighborhood of Nantes, and Coüeteux refers to the want of success, in his own cases, of ordinary treatment of the conjunctiva. He gives notes of one case, in a lad of 16, in whom no real improvement in the eye symptoms resulted from local treatment by means of calomel, bichloride of mercury lotion, etc. Despairing of effecting a cure, the author proceeded to relieve the patient of his naso-pharyngeal disease, viz., adenoid growths. The applications to the eyes were left off. Improvement of the conjunctival disease quickly followed removal of the adenoid growths, and after a second operation upon the nose and pharynx, the patient entirely recovered from all ocular symptoms.

Trousseau refers to four cases under his care. The first was very similar to Coüeteux's, both as regards ocular and nasal symptoms, treatment and progress. In the remaining three no adenoid vegetations were found in the naso-pharynx, but other definite changes in the mucous membrane and the middle and inferior

turbinated bones were present. In these three cases treatment of the nasal and pharyngeal disease had no very decided effect upon the conjunctivitis.

Although neither author maintains that naso-pharyngeal disease is alone the cause of the conjunctival affection known as spring catarrh (Coüeteux suggests calling it nasal conjunctivitis), the evidence they bring forward is sufficient to render it very desirable to have the nose and pharynx carefully examined in all cases, or at least in those which do not yield to ordinary methods of treatment.—*The Ophthalmic Review*.

TO REMOVE GLASS BEADS FROM THE EAR.—For the removal of glass beads from the ear it has been newly recommended to melt alum in a spoon over a flame, dip in the molten mass the end of a thin rod of wood, separated into its component fibres, and to introduce the rod into the ear and lightly press against the foreign body. After half to one minute the now adherent bead may be withdrawn. The meatus is protected from injury by a funnel of stiff paper.—*Provincial Medical Journal*.

PRELIMINARY DRILL FOR LARYNGOSCOPY.—Apart from the unwillingness of the patient there is often an utter inaptitude to understand what the doctor requires. To many people it is most difficult to inspire and expire, or phonate to order. In such cases much time is saved by a little patient instruction,—“breathe gently in and out,” “say hah,” “draw breath.” This having been overcome, the larynx may be seen for a moment—and the early laryngoscopic examination should be of the briefest possible duration. In point of fact, it is a good rule on the first introduction of the mirror merely to insert it for a moment into the back of the mouth, and then to remove it without having made any serious attempt to see the larynx, but *on no account to appear to the patient disappointed at not having done so*. The examination can usually be accomplished easily and confidently on a second introduction.

We find in the rules that the examination of the interior of the larynx is much facilitated by the patient uttering a note in the “falsetto,” “head,” or “thin” register. Now the difficulty is to get an untutored patient to do this. Vocalists do it without difficulty, and many adaptable patients do it by imitation. There is no question in my mind that the power of communicating this accomplishment to the patient is of unspeakable value to the laryngoscopist, and well worth the trouble of acquiring. If the patient can be got to utter the sound “beh” to a head-note, the knot of the difficulty is generally cut. This sound is not familiar to the English throat; it is like the vowel of the word “hell” long drawn out, the “meh” of the sheep, the “ê” of the French “bête,” or the Scotch exclamation of surprise “Eh!” During the utterance of this sound the larynx is raised into a more favorable position for inspection than when the vowel “ah” is produced, and the mouth is not closed to such an extent as during the emission of the sounds “ay,” or “ee.”

After acquiring the art of pronouncing this vowel, it remains to get the note uttered on the “head” or “thin” register, and this is really the *crux* of the “preliminary drill.” Those who cannot hit off a falsetto note at once may succeed if they commence singing a scale as softly as possible. At a certain stage they will notice the character of the tones alter, and the sense of effort at production becomes less. They will find themselves using the “thin” register. One method, then, is to make the patient sing the vowel “eh” very softly up the scale, and when he has reached the “thin” register, to make him halt, sing several times the note required and, finally, to emit it “with a will” when the mirror is introduced.

There is yet another method of “dodging” a patient into the use of the “head voice.” Patients who are insusceptible to musical methods may succeed in producing a head-note by imitating a little girl calling to her kitten, “puss, puss, puss,” on a very high-pitched note. Others may pick up the comic singer’s method of testing his head-register by trying to reproduce the voice of an irate woman, shouting “Eliza-ah,” the last syllable being pronounced on a high falsetto note. The grotesque effect of this proceeding is very “catchy,” and often overcomes the difficulty, the transition to the sound “eh” being easy when once the patient has caught the idea. In cases of destruction of the vocal cords and other conditions the productions of the sounds described may be possible. Let it be remembered that it is not so much the actual production of the sound as the attempt to do so that is required.—Dundas Grant, *Journal of Laryngology*.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,

WITH THE COLLABORATION OF FRANK H. PRITCHARD, M.D.

TREATMENT OF PHTHISIS.—Jousset, after speaking of the general treatment of phthisis, including prophylaxis, feeding, exercise, hydrot'herapeutics, general hygiene and climatology, gives the following remedies with their indications:

Drosera.—Tradition has long assigned this remedy an important place in the treatment of phthisis. Borrichius, quoted by Hahnemann, testifies to the fact that this plant produces a very violent cough in sheep. Dr. Currie has produced tuberculosis in cats by the long-continued use of *drosera*. It is indicated in phthisis when there is a fitful convulsive cough, with vomiting of food and watery substance; or an incessant slight, frequent dry cough, excited by tickling in the larynx, at the base of the throat, and sometimes at the palate. It should be remembered also that the cough of *drosera* is sometimes of a suffocating character, and associated with coryza, sneezing and epistaxis. The therapeutic action of *drosera* is stronger than is generally acknowledged. With Drs. Currie and Cretin, Jousset recommends it highly as a curative remedy in pulmonary phthisis. Strong doses are necessary; twenty drops of the tincture should be dissolved in four spoonfuls of water, and this quantity should be taken in the course of the day. In some cases Jousset has used as high as forty drops in the day, but a long clinical experience has taught him that it is not necessary to use the larger dose. In a certain number of cases a temporary aggravation of the attacks may be noticed to follow the use of too strong doses. The drug should be continued, perhaps, for years, beginning with the weakest dose and increasing gradually and progressively. Its administration may be suspended according to the effects produced or as needed by complications or new symptoms. It is also advisable to stop the drug from time to time, in order to give the organism an opportunity to show its curative action.

Iodide of arsenic and calcaria phosphorica.—Dr. Martiny, of Brussels, has recommended these drugs to be given in alternation. Jousset has experienced good effects from this treatment in common phthisis with little or no hectic fever. Martiny usually employs the 6th dilution on globules. One day one remedy is given and the next day the other.

Silicea is an important remedy in advanced cases when cavities have formed and there is hectic fever. Its indications are: Convulsive cough, resembling somewhat that of *drosera*, with this difference, the tickling is situated lower down in the larynx and in the suprasternal fossa, while the tickling of *drosera* occupies mostly the upper part of the larynx and the throat. The cough is racking and suffocating, keeping up for hours without interruption, and at times provoking vomiting. The expectoration is at times of a transparent and salty mucus, and at others (this latter is the general condition) of purulent matter. The general symptoms are hectic fever, colliquative diarrhœa, insomnia, sweat mostly about the head, emaciation and prostration. Jousset recommends usually the 30th dilution, two or three doses daily.

Phosphorus, arsenic, ferrum aceticum, laurocerasus, digitalis, calcaria carbonica, and *iodium* have been recommended in the treatment of acute phthisis. Jousset has treated one case successfully with phosphorus. This latter remedy is indicated when the symptoms are similar to those of pneumonia. The cough is painful, dry; the sputa are more or less mixed with blood, sometimes even being composed of pure blood. The breathing is short and painful, with a choking sensation; lancinating pains in the side, aggravated by breathing; the fever is of a remitting type;

emaciation rapid. Dr. Richard Hughes succeeded in checking the course of a case of acute phthisis by the administration of *arsenicum* 3 and *phosphorus* 2 alternately, one day of one and the next day the other remedy. This same author mentions another case in a child rapidly cured by *iodium* 3x. Hartman recommends *ferrum acetikum*. This drug is indicated when the cough is incessant, excited by tickling in the larynx; vomiting of food immediately after eating; painful oppression of breathing; ephemeral pulmonary congestion and hæmoptysis; fever-pale countenance, with flushes of heat. Clotar Mueller recommended *iron* especially when hæmoptysis was present. Dr. Pope reports a case of acute phthisis cured by the alternate use of *arsenicum* and *calcareæ*.

Laurocerasus has been recommended by Hartlaub and Trinks, who claim to have cured with it a case of acute phthisis with incessant cough and expectoration of copious gelatinous mucus with blood. Gross has reported a similar result.

Digitalis was recommended by Hartman when there is great excitement of the vascular system; expectoration is streaked with blood; lancinating pains about the præcordial region, palpitation with constriction about the chest.—*L'Art Medical*, November, 1891.

TREATMENT OF THE COMPLICATIONS OF PHTHISIS.—FOR THE COUGH: *Hyoscyamus*, for incessant cough at night, forcing the patient to sit up in bed, with vomiting or efforts at vomiting; the cough is excited by tickling in the trachea.

Conium.—Indicated under almost the same circumstances as *hyoscyamus*; but the tickling is often subternal.

Laurocerasus in frequent cough is indicated by the symptoms mentioned in the preceding article. Usually the 6th dilution is the most efficacious, both for this drug and for *hyoscyamus*, but there are cases where larger doses should be used.

Opium and its preparations are very precious remedies in large doses, for the relief of the cough; but they should be used only in hopeless cases, and as a palliative to calm the last moments of the poor sufferer.

Dyspnœa.—When this is very marked, *ipœcac* and *carbo veg.* are both valuable remedies. *Ipecac* is indicated when the dyspnœa is sibilant, with difficult breathing. It should be used in the 1x trituration, 25 centigrammes in 200 grammes of water, a spoonful every hour.

Carbo veg. is indicated when the dyspnœa is associated with a feeling of constriction in the chest.

Inhalations of oxygen afford an efficacious means of relieving dyspnœa at times.

DIARRHŒA.—*Arsenicum* first centesimal trituration is the most frequently employed remedy. Should it fail, we suggest phosphoric acid, 1x dilution. *Cotoïn* and *rhubarb* are also valuable, the former in the 1x trituration, and the latter from two to ten drops of the mother tincture per diem.

SWEATS.—*Phosphoric acid* will relieve this symptom when it becomes excessive; it will also meet the colliquative diarrhœa.

Sambucus also has great power in moderating the sweats, especially those occurring at night.

Jaborandi produces sweats. Jousset says he has used it successfully in phthisical cases in the first trituration.

PAINS.—In the last months of the disease phthisical patients suffer from pains in their limbs. *Bryonia*, *eupatorium* and *rhus tox* come into play. The pains of *bryonia* are worse from motion, and oblige the patient to keep quiet. Those of *rhus* are relieved by motion and by frequently changing position; and those of *eupatorium* force the patient to get out of bed without this change giving any relief. All these remedies should be used in the low dilutions or the mother tincture.—*L'Art Medical*, November, 1891.

DR. MACFARLAN'S PROVINGS AND CLINICAL OBSERVATIONS WITH HIGH POTENCIES.—For a number of years Dr. Malcom Macfarlan, as is well known, has been carefully making independent provings of a large number of remedies, the conditions being such that the subject was unaware that the proving was being made, and consequently was not in an expectant attitude, waiting for the onset of symptoms. These provings and clinical observations he now publishes for the first time.

Aconite 50m. caused such free sweating, to use the patient's language, you could have wrung out his shirt. It checked or modified night-sweats for awhile in a number of consumptives, and moved the bowels three times a day, liquid stools.

Almost the first effect of highly potentized aconite is to cause perspiration quickly. Profuse sweat during sleep. Great inconsolable anxiety. Anxious feeling. Rash-like measles, lasting only a day or so. Free sweat, with pain in joints and muscles.

Actea racemosa 5c., given to a man every hour during the day for two weeks caused slightly bloody urine; urination frequent. Sick feeling in epigastrium; costive. It was noticed that it suppressed menstruation in a certain number of females, in addition to urinary symptoms.

Adeps suis 1m.—Constipation, hard, dry stool, cramps in the stomach; bowels that were constipated now moved daily; weakness after the stool, cramps about the navel, severe pains between the last lumbar vertebra and sacrum; such great weakness behind her knees in popliteal space that the prover could hardly get up; hips and elbow painful on motion; hard, dry and insufficient stool, not easily expelled; caused bowels that were constipated to move daily. I have frequently verified this in curing constipation when there was loss of expulsive power in the rectum. Stools hard, dark and dry.

Esculus 50m.—Headache, drowsy, walking difficult, so weak; legs ache. All provers complained of extremities being much affected; bowels loose; hands and face swell up enormously and increased so after washing; pimples appeared on face and body. This was noticed only in one case, where medicine had been given for several weeks. Many pimples on the face; few on the body in most provers.

Agaricus muscarius 47m. completely relieved a severe bearing-down sensation in the uterus, which I had been treating unsuccessfully off and on for a year and a half. After some weeks it returned slightly, when she had not been taking the remedy, but was cured by a second exhibition of it. Soreness in the ovaries. Given to a number of females, produced general stiffness; arms and back of neck stiff; little hard, red pimples scattered all over the body, like flea-bites. Never has been so sleepy as during this last week (second week of the proving); beating on top of head toward forehead; cured bearing-down pain; very thirsty; never has been so thirsty; twisting pain in the umbilicus; pain in both hip-joints; gets up stiff, like an old rheumatic; stiff joints in general; soreness deep in two spots four inches on either side of middle of sternum; hurts or weakens her to breathe deeply or speak continuously; little, hard pimples break out on side of her nose and about her lips. Given every hour for a week caused cramps and chills, as if she were going to have the ague; couldn't remain up; had to lie down; had to pass water all the time; severe bearing-down pain when she attempted to walk; talking in a loud voice and deep breathing hurt her in the right ovarian region; bowels now move twice a day instead of once. These symptoms were most violent on the third day.

Agaricus musc. 2m.—Sick at stomach; threw up a good deal; abdomen very sore; below the navel sore to touch.

Ailanthus 45m.—September 20th, 1872, Mary W., widow, aged 40, medicine every two hours during the day. Symptoms after a week: Had a slight trouble with her knee, as if sprained; had always been in good health; if she touches or presses her lip it will puff up and appear to be sore; there is now a ragged, deep little sore near the angle of the mouth; the lower lip has a crop of angry blisters about it; violent itching sensation about the ears, back of the neck, and less in degree about the face; the skin has divided off into red, raised blotches; intense desire to scratch the blotches; a water blister came on the end of her thumb; small blisters appeared at tips of fingers; her chin one day was bright scarlet; another day her ear had the appearance of erysipelas, from slight rubbing; skin of face very itchy and becomes very red on the least rubbing. Curative in a case of chronic acne in a young girl.

Alcohol sulph. 50m.—Pains nearly every day, mostly after dinner, in head, through temples, very sharp; numb all through top of her head, in scalp.

Aletris farinosa 45m.—Severe pains in the rectum or anus; frequent desire to have a stool; diarrhoea on second, third and fourth day; the pain when she had a movement was violent; felt as if she was forcing a passage through an obstruction; feeling of exhaustion; when she stoops down, gets dizzy; eyes feel sore and dim; spits a good deal and raises mucus; feels as if she wanted to cough and cannot.

Alumina 91m.—Can pass urine only during stool; frequent stools; stools with traces of blood.

Ammon. carb. 5c.—Given for ten days every two hours, produced a red rash-like erythema, with a great deal of heat; burning and fever; burning feeling eruption; skin raised in welts in some places. Dry cough at 3 A.M., or towards morning, occurred in a number of provers.

Antimonium crud. 60m.—Eyelids inflamed; water a great deal; can hardly keep them open; feels sleepy; eyes feel as if too heavy to keep open; very sore; worse in morning; left eye most inflamed.

Apis mellifica 85m.—Loose bowels; watery, green, slimy stools; no vomiting, etc. (Repeated verifications of this.) Cured with this remedy many cases of cholera infantum. Frequent green stools, with disposition to congestion of brain: starting, jerking, eyes rolling; later on, disposition to constipation. Caused great tearfulness or disposition thereto, verified many times. Quickly checked shrill screaming in a severe case of congestion of the brain, young child teething. Cured a very bad case over a year's standing of chronic diarrhoea, with many small passages of blood and mucus in a woman at critical period. Curative in difficulty of urination common to children. Often relieved very red enlarged tonsils. Scalp sensitive in many provers.

Apium 69m.—Dull aching in forehead; severe pains in bowels; sharp pains in ear when chewing or moving jaws; eyes feel as if sand in them. Some provers vomited while taking this remedy.

Apocynum c.n. 60m.—Feels as if she was hungry; and when she tries to eat, food appears to settle in the epigastrium, becomes sour; continued distress in epigastrium, feels as she could do nothing but cry; does not want to speak, very low-spirited, weeping; tongue greatly coated, brownish white, dizzy, headache, drowsy in afternoon, restless and wakeful at night. Urine pale and greatly increased in quantity. Patient becomes very drowsy and vomits often; pulse is very slow. Cured a most inveterate case of wetting the bed at night in a girl aged 20, affected all her night life, and treated by many without success. Cured general stiffness of legs and body, painful on motion. Cured frontal headache, sick at stomach, restless at night. Stiff knees often verified this symptom—stiffness not similar to rheumatic trouble.

Aranea diadema 45m.—Male prover. Produced a boil on left side of penis, near pubes; constant desire to pass water, but with difficulty. Severe pain along the urethra, extending from the glans. Woman, misty sensation before eyes; felt so tired that it appears as if she would drop; bowels now move daily, which were four or five days constipated. Vivid dreams, screams out, and cannot sleep again. After taking the remedy two weeks, had to stop it, as it partially suppressed the urine. He passed only four or five ounces of it during the day; no burning. Urine appeared darker than natural; had to stand and wait a long while before it would come. Sensitive to pressure on either side of the bladder; no energy. Urinary symptoms verified in other provers, showing diminished secretion.

Argentum nitricum, 45m.—Swollen left side of face, with a great deal of heat and burning; lips greatly swollen, inside of the mouth much swollen; earache, marked soreness in flesh and limbs. Female provers. Every hour during the day for two weeks, produced a rash like scarlatina at first, then papular eruption, which changed in a few days to a crop of small boils, half the size of a pea, all over the body. (One prover.)

Arsenicum album, 103m.—Sick at stomach; did not vomit; great weakness; dizzy headache on top of head; no appetite; no particular thirst; slight fever and sweat every afternoon; some difficulty in breathing, like asthma. She was compelled to lie down, she was so weak; her left ear discharges slight moisture; face swollen up, sighing for breath, panting on exertion; bowels have been regular; watery discharge from nose, fainted several times during the week.

Arsenicum album, 6m.—Appears to be most useful in ophthalmia when photophobia is present. Fainted several times when walking out. She had never fainted before. Had been taking the medicine four days when this occurred. Cannot sleep after 3 A.M. She gets up in a fright from vivid dreams. Very low-spirited. Night-sweat, chilly and feverish, mostly towards sundown. Throat quite sore and painful, backaches, buttocks sore to the touch, appears as if a lump came like a hurt in her throat. It seems as if she was swollen throughout her whole body, pain extending from her head to her right shoulder and down her right side. Could not sleep because of anxiety. Fear that some evil will overtake her. Prover awakes in a horrid fright at 3 A.M. Cannot be convinced but that something dreadful will happen to him. Fainting in a woman when out walking, verified often, never happened before. Cured a case of ascites following chronic diarrhoea. Made comfortable many cases suffering from chronic Bright's disease, with general dropsy. Eyes misty at times, fainty feeling, could not see well at times, eyes not inflamed, did not water, feels as if she had a load in upper part of both lungs, feels

as if she would smother. Highly curative in some cases of scrofulous ophthalmis and ophthalmia tarsi, where the disease is communicated, as in children. Cured cases of scald head, belching, frequent and small stool, inability to sleep well because of mental anxiety. In giving arsenic to those with ophthalmia, it produces great intolerance of bright sunlight, not candle or gaslight. Caused feeling of weakness, as if he would faint.—*The Homœopathic Physician*, December, 1891.

AMMONIUM CARB., is a useful remedy in coryza, also in sore throat where the feeling is as skinned. Frequent fainting and great failure of strength is a good general indication for the drug.—*California Homœopath*, November, 1891.

STRYCHNIA competes with quinine in its beneficial effect in chronic ear diseases—chronic unvarying tinnitus is characteristic of it.—*California Homœopath*, November, 1891.

RAPID RELIEF OF COLIC FROM ACONITE.—Dr. Stanley Wilde reports the case of a spare married woman of nervo-bilious temperament, to whom he was summoned at night. She was in great pain, rolling about the bed in agony, and in a state of much mental as well as physical perturbation. The pain which she described as if she would burst, was referred to the descending colon. The abdomen was not tympanitic, but the descending colon appeared puffed out, and there was fecal matter at the sigmoid flexure. The patient is subject to attacks of incarcerated flatus, and has hitherto always taken belladonna on her own account with marked relief and subsequent emission of flatus. In this instance it had failed to produce the usual effect. Dr. Wilde at once gave her *aconite* 1x, made from Fleming's tincture. Inside of a few minutes the pain had entirely ceased. The cessation of pain was not accompanied with or followed by any emission of flatus. The patient passed a good night, sleeping well, and not needing a second dose of medicine.—*Monthly Homœopathic Review*, November, 1891.

CAMPHOR IN URINARY DISEASES.—Dr. Jos. Thornley reports the following, cases of urinary disease treated with camphor: CASE I.—A man æt. 40 years, while on a railway journey was seized with pain in the left lumbar region with vomiting followed with suppression of urine. The case was diagnosed as one of renal colic. Treatment consisted of hot fomentations over the region of the kidney, and extending around the side and down the left groin. The pain in a few hours spread along the entire course of the ureter, and into the left testicle, which was retracted beneath Poupart's ligament; this latter condition caused very violent pain, and the sickness was attributed to this cause by the patient himself.

Medicinally, cal. carb. 30, was administered every hour. Ice allayed the sickness and quenched the thirst. This in conjunction with the hot fomentations brought complete relief in twenty-four hours. The urine though now clear, was high-colored, and was found to contain uric acid, though not in great abundance. The patient remained well for another twenty-four hours when he had a renewal of the attack with all its previous symptoms, this attack lasting three days. The urine during this attack contained greater quantities of uric acid than before. He now suffered from strangury, the pain lasting for some time after each act of urination. For this camphor θ , was given, three drops on a lump of sugar every three hours. Within an hour the pain was relieved, and in twenty-four hours had entirely gone and did not return.

CASE II.—A married woman aged 30 years, complained of great pain after micturition, with constant desire to pass water, and a feeling that the whole of her urine had not come away; this caused her to have what she called heavy bearing-down pains, and straining to force more urine away. The pain she said was like a knife cutting her, and it was so severe that she was in great fear of the desire to urinate coming on. Fomentations of hot water to the parts were ordered with camphor θ , three drops on sugar every three hours. She was much improved the next day. Improvement continued steadily until she was entirely cured.

CASE III.—A married woman, aged 40, complained of much pain in the region of left kidney and ureter, and bearing-down, scalding pain on passing water. Camphor θ , three drops on sugar every four hours. Next day she was much improved. The strangury had entirely gone, and the pain in her side and back was much better.—*Monthly Homœopathic Review*, October, 1891.

SYMPTOMATOLOGY OF COCAINE.—Taking the symptoms of cocaine as reported in medical literature, Dr. A. F. Storke has arranged the following schema of the symptomatology of the drug:

General.—Twitching of the body; pleasant tremors through the body; lateral pendulum-like motion of the body; muscular power enhanced; convulsive movements; tetanic convulsions; diminishes tissue waste.

Mind.—Talkative; repeats same idea over and over because words fail to express the delightful sensation; then sober and foolish; every breath stimulates; feels as if he "had taken a big drink of whisky;" cerebral activity, even delirium; but always subservient to a powerful effort of the will; semi-comatose, easily roused; answers with difficulty; at first calm, later ecstasy; may be terror and anxiety; least sound terrifies.

Head.—Aching, throbbing, bursting hemicrania; fantastic images; drowsiness, with oppression of head and confusion of thought if resisted; vertigo on awakening.

Eyes.—Sunken, but seem protruded; tension in lids; conjunctiva first pale, then red; pupils at first contracted, then greatly dilated; astigmatized; letters appear to start from left to right; ocular tension lowered; power of accommodation never entirely lost.

Ears.—Ringing in ears; deafness.

Face.—Pallor; cyanosis; puffiness; flushes coming and going rapidly; clammy skin; twitching of facial muscles.

Mouth and Throat.—Tongue dry and anæmic; numbness of tongue; incoherent speech; dry, leathery feel in mouth; burning in palate; bitter taste; sometimes taste lost; fauces dry; warmth in pharynx; deglutition and articulation difficult.

Stomach.—Anorexia, nausea, retching, vomiting; cramps following eating; pressure in epigastrium; gripings constant; warmth in stomach; vacant feeling.

Stools and Urinary Organs.—Increased intestinal peristalsis, followed by sluggishness and paralysis; constipation; sexual functions ceased; burning on micturition; ischuria; urea decreased; crystals of calcium oxalate sometimes found in urine.

Respiratory Organs.—Dyspnoea; respiration rapid, very easy, superficial, and principally thoracic; frequent inclination to sigh; can not draw a long breath.

Heart and Pulse.—Suffocative feeling in cardiac region; heart's action may be increased or retarded; pulse rapid and weak; pulse intermits every fifth beat.

Extremities.—Fleshy part of arms and legs insensible to pinches, etc.; heaviness of legs; tingling and numbness in hands, especially right hand; cramps in legs and feet, especially right foot; legs weak and lose their power.

Sleep.—Sleepiness, gives way to feeling of great energy; wakeful feeling, with weakness of legs while walking; sleeps thirteen hours.

Fever.—Coldness; hands cold and clammy; rise of temperature, with cold shivers and chattering of teeth; skin hot and dry; sweat, then prostration and fears of death; cold on neck or face; clammy cold on forehead; remarkable rise in rectal temperature, preceded by a slight fall.—*Medical Current*, November, 1891.

CALCAREA CARBONICA IN CEPHALAGIA.—Dr. Mersch, of Brussels, Belgium, was consulted by Miss A. V., aged 28, an anæmic person, who complained of headache appearing about every fifteen days. The pains were lancinating, situated in the forehead and above the eyes upon one side, and extending into the temporal region, sometimes running into the back of the neck. It was sometimes accompanied by nausea and vomiting, and lasted, as a rule, from one and a half to two days; if vomiting did not set in, the headache would persist somewhat longer. She suffered from habitual constipation; no hæmorrhoids; periods normal and not painful; no appetite; empty sensation in the epigastrium, every morning towards 6 o'clock; typhinitis; tongue large and pale, with imprint of the teeth on its edges; pulse feeble, 80 per minute; urine normal; no rheumatic tendency; great nervousness. *Nux. com.* and *sepiæ 6x* were prescribed and relieved the symptoms somewhat. A companion of the lady related that she was timid and would not remain alone. When in a theatre or concert she would be seized with an imperious desire to leave the place, which she would do at any cost, even if she would have to annoy those near her, or in spite of the entreaties of her parents. Once outside, this impulse would leave her and she would regret her action. Basing his prescription upon this hint he prescribed *calcarea carbonica*, 30x and 24x

(Hahnemann, *Chronic Diseases*, vol. i., pp. 540 and 546.) This was followed by a complete freedom from her attacks. The drug was repeated in the 18x, 15x, 12x, 9x, 6x, and, finally, 3x. Four months after she had had no attack and could be regarded as definitely cured.—*Revue Homœopathique Belge*, No. 4, 1891.

CALCAR. CARB. IN RHEUMATISM.—Mrs. B., æt. 61, suffered for the past two years from a swelling of the left wrist joint, as well as of the neighboring soft parts. She had formerly suffered from cardialgia with distension of the epigastrium. Menses copious and antepoising during the whole of the time that she had them. Wet and drafts were injurious to her. Relief is found from the warmth of the bed. Functions otherwise apparently normal. Motion of the affected joint is scarcely possible. On August 9, 1889, she received calcar. carb., a dose every seventh evening.

On the 18th of September she reported that the joint was more movable; swelling lessened. The remedy was continued.

On November 4th the joint had recovered its normal motility and the swelling had almost entirely disappeared.—*Allegm. Homœop. Zeitung*, August 7, 1891.

PHOSPHORUS IN IMPAIRMENT OF VISION.—Mrs. K., æt. 62, was treated in the eye dispensary about a year ago for "bad eyes" without obtaining any relief. Since about four weeks ago she complains of right-sided headache, vertigo, sleepiness during the day, must lie with the head high, cannot bear wind or sunlight, oppression when lying upon the back; cannot lie on the left side. Her sight is so impaired that she is afraid to go on the street unless she has some one to lead her. Constant appearance as though smoke was in front of her eyes, as though the whole room was full of smoke. Her other functions were about normal. The pupils were large and the iris hardly reacted at all to light. The eyeballs are perhaps somewhat more resistant than normal. Phosphor. 10, was prescribed, a dose every seventh evening.

On July 9th she reported that the headache had almost completely disappeared. She came without being led by any one, and could go about everywhere without feeling any uncertainty. Some time later she came under observation accidentally, when she said that her vision was about normal and as before she noticed an impairment in her sight.—*Allgem. Homœop. Zeitung*, August 7, 1891.

PLATINA IN MELANCHOLIA.—Mrs. W., æt. 43, a robust woman who had always been well, has suffered for several years past from melancholy with attacks of sudden anxiety. The attacks appeared periodically; in the beginning the intervals would last some weeks, but of late the well periods were becoming ever shorter. Menses have always been irregular. The menstrual blood was partly clotted and had a bad odor. Sleep was, on the whole, refreshing, although at times she would have some difficulty in falling asleep. Frequent creeping sensation in the feet, arms, and hands. Her mood, even in her bad days, was changeable. Boring sensation in the epigastrium at times. Occasional palpitation of the heart when lying on the left side at night in bed. She could not stand hot oppressive air nor the sitting posture.

A vaginal examination brought to light that she suffered from an induration of the neck and body of the uterus, with painfulness to touch. Uterus was rather less movable than normal. She had passed through two normal confinements and recoveries, the youngest child being twelve years old. Platina 12, was prescribed, a powder every seventh night.

On August 12th she reported that marked improvement had set in. All functions were normal, the creeping sensations were much better, her mood was normal with the exception of very short attacks of slight depression. After taking six more doses she determined to discontinue treatment against advice.—*Dr. Kunkle in Allegm. Homœop. Zeitung*, August 7, 1891.

PLUMBUM IN MIGRAINE FROM INTERSTITIAL NEPHRITIS.—Dr. Mersch, of Brussels, records the case of a lady past the menopause, who consulted him for migraine. The climacteric was accompanied by no disagreeable symptoms. The family has a gouty, and especially a rheumatic history. These headaches came on every five or six days, and lasted usually twenty-four hours. They were sometimes accompanied by nausea, but not always by vomiting. The pain was situated in the left temple and was described as feeling as if pressed; no pulsation. She was of a florid habit. The pain was not aggravated either in the evening, night or morning. The pains had no special hour of appearance. The urine deposited no sediment, but

was rather light-colored; the stools were normal. The appetite was good; the tongue clear; the pulse 65, regular and strong. The radial artery was indurated; sphygmographic tracings showed the characteristic ascending line of arterio-sclerosis. In childhood she had had rougeola and some (tuberculosis) joint disease. She slept well, except certain nights, when she was unable to close an eye, because of a certain fear which possessed her, and which she could not define nor attribute to anything. For about ten years she suffered more from this than before. It even pursued her during the day, even if she were not alone. Yet she regarded this idea as ridiculous. The writer prescribed *calcareæ c.*, but with unsuccessful results. Palpitation and slight dyspnoea were developed by the second examination of the patient, as well as an accentuation of the first cardiac sound; no perceptible hypertrophy present. *Plumbum carbonicum* 12x. was prescribed and with some relief. The urine analysis revealed nothing in particular, excepting a lowered specific gravity—1012–1014. *Plumbum carbonicum*, 6x. The patient continued gradually improving, the headache became less and less, the accentuation of the heart-sound very slowly yet gradually diminished, until, four months after prescribing the *plumbum*, she could be considered cured.—*Revue Homœopathique Belge*, No. 4, 1891. "No remedy, however, so closely corresponds to the general phenomena of the malady ('gouty kidney') as the atheroma, the cachexia and the depression of spirits; the amaurosis of the two is precisely similar."—*Dr. Richard Hughes*. Dr. Garrod (*Gout and Rheumatic Gout*; London, 1859), points out the occasional relation of lead to gout and gouty changes, and cites six cases. Tanguerel (*Lead Diseases*) does not mention it. In a recent article in a French journal on chronic plumbism, there was a complete pathological picture of interstitial nephritis—red and granular kidney—given with the subsequent effects upon the various organs, cardiac hypertrophy, etc.

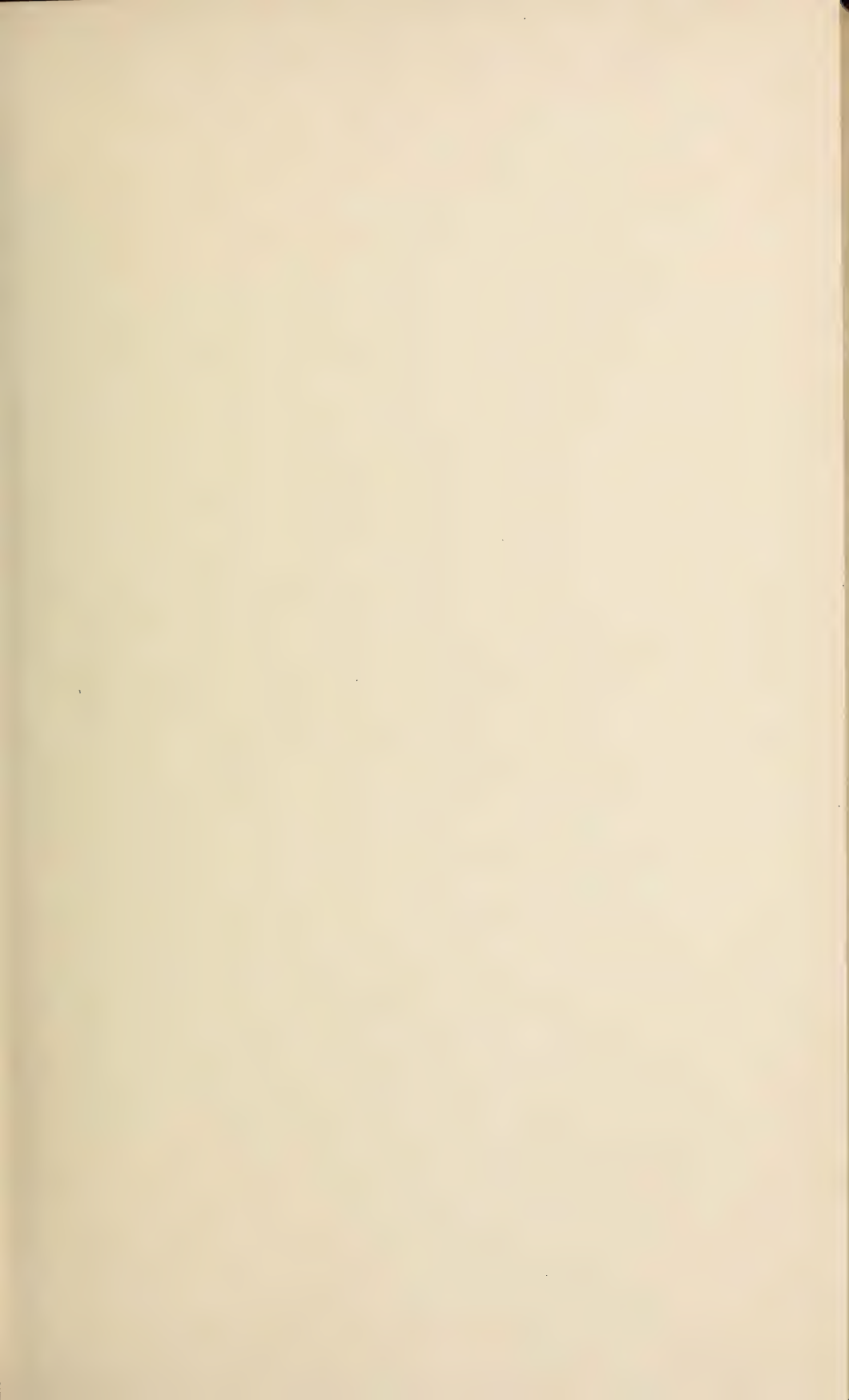
MEDICINAL TREATMENT OF NASAL POLYPI.—Dr. P. Jousset, of Paris, France, resumes the treatment of polypi of the nasal fossæ. The more frequently indicated are *calcareæ carb.*, *teucrium mar.*, *hepar sulphur.*, *phosphorus*, *staphisagria* and *thuja*.

Calcareæ carbonica.—This remedy counts the greatest number of successes; it should be administered with perseverance; two doses; wait six days, then recommence. The 18th to the 30th dilution may be used.

Teucrium marium.—This is a popular remedy in nasal polypi. It was employed before Hahnemann's time, as a powder to be insufflated into the nares. It may be administered like *calcareæ carb.*, but in the third trituration, together with the first trituration as a snuff.

Thuja.—*Thuja* being the principal remedy in fig-worts and verrucæ it is naturally indicated in polypi. The writer has used it with success in a case which has, since years, not recurred. He alternates *thuja* and *nitric acid* in the 6th attenuation. At the end of fifteen days the polypus ulcerated; *thuja* was continued alone for six months, it being given for fifteen days, with a pause of the same time. The result of this treatment was the falling out of a mucous polypus of the size of an almond. *Phosphorus* is indicated when the polypus is accompanied by repeated hæmorrhages. The other remedies, *staphisagria* and *hepar sulphuris*, have no special indications.—*Art Médical Revue Homœopathique Belge*, No. 6, 1891.

EPITHELIOMA OF THE LEFT MALAR PROMINENCE SUCCESSFULLY TREATED BY THE CHLORATE OF POTASH AND THE MURIATE OF HYDRASTINE.—Dr. P. Vera, of Bogota, Colombia, S. A., was called to see a lady 83 years of age, who presented a small nodule of the size of a button, situated upon the left malar bone, having a verrucous appearance and undergoing ulceration. It had sprung into notice three years before. A similar tumor was situated upon the upper part of the right cheek. As constitutional treatment the chlorate of potash and the muriate of hydrastine, both in the 3d trituration, to be alternated every six hours indefinitely. A cure was obtained in four months.—*La Homœopatia*, September 20, 1891. Mr. Hutchinson has clearly demonstrated that the long continued use of arsenic will produce epithelioma. Five cases are given.—*Jour. of Cutaneous and Venereal Diseases*, p. 344, 1888. Dr. Hanford (*ibid.*), related a case to the Clinical Society of London, where a 13-year old child with chronic pemphigus took Fowler's solution, 15 gtt., three times a day, for ten weeks, therewith producing, besides a dark pigmentation of the skin, elongated patches of thickened epidermis and white points beneath the skin resembling miliary tubercles; these cutaneous tissue-changes were probably due to accumulation of degenerated epithelium in the deeper parts of the epidermis. These changes had disappeared four or five months after leaving off the arsenic.





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HONORARY PRESIDENT OF THE INTERNATIONAL HOMŒOPATHIC CONGRESS, 1892.

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THE SIGNIFICANCE OF BACTERIOLOGICAL DISCOVERIES TO THE HOMŒOPATHIC METHOD OF TREATMENT.

BY D. P. MADDUX, M.D., CHESTER, PA.

(Read before the Organon Club of Chester, December 10, 1891.)

IN approaching a subject of such vast and vital importance, and one that obtrudes itself so largely into *terra incognita*, it is important to, as far as possible, get one's mind into a state of judicial fairness, to seek for truth as truth, and to permit prejudice, fads, and preferences, to have no part in the decision.

We should endeavor to consider the subject, not as sectarians, and declare in favor of the homœopathic treatment of all diseases of a bacterial origin, merely because we are believers in homœopathy; on the other hand, we should not be carried away into the belief and practice that, because bacteria are the tangible and presumable exciting cause of so many diseases, they, as bacteria, must be neutralized in some tangible and direct method. The believers in homœopathy need not approach the study of bacteriology with the slightest fear that it will destroy the well-grounded temple into which they have built their hopes and allied their destinies.

All truths are members of one great brotherhood; what is true in homœopathy cannot possibly suffer any evil effects from the discovery of other truths; in fact, it can but be benefited by the revelation and demonstration of any or all facts relating to the animal economy. It is possible that such discoveries may lead to some modification in

treatment of a limited number of diseases ; it may relegate more cases to the care of the surgeon ; it may take from him some that he has at present pre-empted ; it may, and I trust will, show us where we make mistakes ; but it will no more destroy the principle of *similia*, as a generally applied one in the treatment of disease, than it will destroy the law of gravitation.

I do not consider it debatable that bacteria are the active, exciting, essential factors in the causation of many diseases.

But, admitting their presence, which no one denies ; conceding their direct or indirect causal relationship to disease, which no one who reads the evidence can successfully controvert ; there still remains a large field of legitimate doubt as to how they affect these changes, as to the conditions necessary in the body in order that these changes may take place, and how their evil consequences may be overcome.

I refer in these remarks to those diseases of presumably bacterial origin, that come strictly within the domain of the physician. In my surgical work, I am an enthusiastic believer in, and practitioner of, the doctrine of antisepticism in its minutest details, but it is in those difficulties where the lilliputian invaders have ensconced themselves in the blood and organs of the interior of the body that I wish to principally address myself.

Bacteria were, and I am afraid are yet, regarded by a great many as an embodiment and synonym of disease ; while a more complete knowledge of their character and attributes would give a much kinder and more accurate judgment, for they include among their number those which make life possible to man and the higher organisms. In fact, they have, for ages, been the unrecognized and unrewarded conservators of more highly organized life, both plant and animal. They purify our drinking-water and assist to destroy the pathogenic germs therein contained ; they are essential to the growth of plant life ; they are the most potential scavengers of the globe, and their better class, which largely predominates, have numerous and powerful vigilance committees, which untaught and untold do more towards subduing their own criminal members than all the germicides man ever manufactured. It is only a limited number of bacteria that are pathogenic ; a much larger number are either neutral or, as said before, essentially helpful to the higher organisms.

But, granted the presence in the body, in dangerous number, of pathogenic bacteria, in what manner can they be most effectually neutralized ?

Is it feasible to introduce into the system, either by sub-cutaneous injection or by swallowing, any medicinal agent, any of those well-known germicides or antiseptics which have been demonstrated by ample tests to be fatal to bacterial life? Drugs which have been clearly shown to be fatal to bacterial life, as it existed in the test-tube, have been administered to patients suffering from diseases of bacterial origin, and were found totally ineffective to destroy bacterial life in the body, except when given in doses equally fatal to the patient. But, even if they succeeded in destroying the bacteria in the body, later experiments would seem to show that they might then augment instead of cure the disease, for the bacteria might, as others who have been murdered, prove more troublesome as a corpse than when alive.

Clearly, then, a purely antipathic line of treatment does not hold out much hope of success; let us, then, glance at methods which have produced more encouraging results, and see in them what lesson is taught.

First, let us ever bear in mind that the natural forces of the body, unaided, are unceasingly at work to rid the body of these tiny invaders; the blood, the lymph, the digestive juices, are all germicides *par excellence*, and all that impoverishes the quality of these fluids, or lowers the tone of the general system, tends to make more vulnerable the organism to attack. In fact, all of us have had in our bodies various pathogenic bacteria, but their number has been so small, or our systemic condition so good, that the natural protective forces of the body were able to overcome them without our becoming conscious of their existence.

The *vis medicatrix naturæ* is still a potentiality, and the use of all methods of diet and sanitation that tend to improve the general health, is just as scientific as it was in the "pre-bacterial epoch." There is no actual contradiction between actual truths.

But let us go a step further, and take a case where nature unaided has been unable to overcome the bacteria, and a full fledged disease presents itself which we are taught to believe, is due to bacteria or their products, how shall we combat it? "Give the indicated Homœopathic remedy," I hear one good Hahnemannian answer; very good, perhaps he is right, but let us be prepared to give good ground for the faith that is within us; but as bacteriologists have met with more success in their experiments on diseases of known bacterial origin, by treatment with substances which produce in the healthy animal similar symptoms, aye, even similar pathological conditions to those in the disease treated, perhaps our assumption is not presumption.

Bacteriologists have long known that there exists in the life products of the bacteria, even when sterilized and separated from the bacteria themselves, certain well-marked and characteristic pathogenic properties, but they are just beginning to appreciate the fact that there exists in pathogenic bacteria, inherent toxæmic, and pathogenic properties, not solely dependent upon their live state, or upon any ptomaine, leucomaine, or any other product of their life activity.

In other words, pathogenic bacteria, by process of filtration and evaporation, have been isolated from the culture in which they grew, and bacteria after protracted boiling have been introduced into the body, with the production of a modified irritation characteristic of the individual species; and why not, if sufficient of them were secured? Bacteria are simple, like cellular masses of vegetable matter devoid of chlorophyl.

Take the juice of the *aconitum napellus*; it is alive while circulating in the plant, but no amount of boiling will change its lethal properties. So with bacteria, as far as experiments have gone, the destruction of life seems but to destroy its power of indefinite division and multiplication, with the accompanied products of its life activities.

If aconite found its proper soil for growth in the body, and a drop would in forty-eight hours or a week become a drachm or an ounce, we would not have an unfair comparison of the power of multiplication of some bacteria when planted in a favoring media.

Pruden, the most delectable writer upon bacteriology living, says, in summarizing his experiments with dead tubercle bacilli injected into rabbits: "We found that dead tubercle bacilli separated from such of their metabolic products, as are set free in the culture media, or are extracted by prolonged boiling in water, or fifty per cent. of glycerine, are capable of inducing marked effects upon the body cells of the rabbit, with which they are brought in contact.

"The dead tubercle bacilli are markedly chemotactic. . . . They are distinctly pyogenic, causing aseptic localized suppuration. 'They are capable, moreover, of stimulating the tissues about the suppurative foci to the development of a new tissue, closely resembling the diffuse tubercle tissue induced by the living germ.'

"We have found that dead tubercle bacilli introduced in small numbers into the bloodvessels of the rabbit, largely disappear within a few hours or days, but that scattering individuals and clusters may remain here and there in the lungs and liver, clinging to the vessel walls for many days without inducing any marked change in the latter.

“After a time, however, earliest in the lung; later, as a rule, in the liver; a cell proliferation occurs in the vicinity of these dead germs which leads to the formation of new multiple nodular structures, bearing a striking morphological resemblance to military tubercles. There is in them, however, no tendency to cheesy degeneration, and no evidence of proliferation of the bacilli, but rather a steady diminution of these numbers. It seems to us that the new structures originate in a proliferation of the vascular endothelium, under the stimulus of the dead and disintegrating germs.”

The animals thus experimented upon all recovered, and at the same time a series of control experiments were conducted with intravenous injection of approximately similar amounts of boiled cultures of the bacillus diphtheriæ, of the bacillus coli communis, of the staphylococcus pyogenes aureus, of wheat flour and of red pepper; these substances were introduced aseptically, and “in none of them were there any alterations in any way comparable to those so nearly uniformly induced by the dead tubercle bacilli, and in most of them there was no reaction or change at all.”

In a later series of experiments published December 5th, 1891, Pruden gives the result of the intra-tracheal injections of dead tubercle bacilli in large amounts under aseptic precautions. Two cubic centimetres (about $\frac{1}{8}$ of a cubic inch) of a milky emulsion of dead tubercle bacilli was slowly injected into the trachea of a rabbit; thirty-four animals were operated upon and killed at intervals from the first to the seventy-second day.

In summarizing the results obtained, Pruden says: “When dead tubercular bacilli are introduced in small flocculi into the air-spaces of the rabbit’s lung, there occurs at their seat of lodgement, first, a larger accumulation of small spheroidal cells in the air-spaces. This is immediately followed by a proliferation of epheloid cells and formation of giant cells in the contiguous air-spaces. Then occur gradual necrosis, disintegration, and absorption of the primary small cell centre, and a conversion of the peripheral zone into a very vascular, cellular, new connective-tissue. Hand-in-hand with the absorption of the microbic centre, the new-formed connective-tissue becomes denser and less abundant, until finally the seat of the lesion is indicated only by a shred or patch of dense connective-tissues, which if the original lesion was not extensive, may be wholly invisible to the naked eye.

“Sometimes, however, but little connective tissue is formed except in the walls of the involved air-spaces; but the nodules persist for

long periods as a congeries of densely packed epitheloid and giant cell masses."

"We now know that dead tubercle bacilli can induce in the living body the development of cell structures which within the limits above indicated, are morphologically characteristic of the lesions of tubercular inflammation. *We do not know whether the living tubercle bacilli are capable of stimulating the body cells to the development of such lesions or not*; because presumably both living and dead germs are present in the ordinary tubercular foci."

In speaking further he says, "This production of a new tissue may not be intrinsically of such practical significance as has been hitherto supposed; or if significant it may be so as a conservative and not as a harmful process."

Here we have, as it were, a miniature panorama, not so much of a diseased process as the method nature takes to overcome and destroy the disturbers of her peace.

Should these processes, if possible, be violently aborted? is it the part of wisdom to check or alter by drugs which act antipathically the course which nature herself has selected as the best?

These nodules, which our old-school brethren would attempt to break down and do away with, are but nature's method of imprisoning and executing these tiny invaders. Here in an irritation and cell proliferation is but nature's effort of restoring health; and can our friends, the enemy, in justice call us unscientific when we use those agencies which simulate in their effect upon the body, the line of action which nature has determined as her own, and thus stimulate and assist nature in her own elected mode. It is notable that the trend of recent experiments in bacteriology is not so much the neutralization of the bacteria by any of the well-known drug bactericides, but the greatest effort of modern research is in the study of the bacterial proteids and natural protective medium found in the body itself, and in this line some noteworthy successes have been secured; but so far as I have been able to read the experiments, *the bacteria or the associated bacterial products which have been injected, either to cure the disease or by inoculation to render the animal invulnerable to it, have produced in the animals experimented upon similar symptoms to the disease treated or inoculated against.* Take for example the celebrated lymph of Prof. Robert Koch, which is stated to be a glycerine extract of pure cultivations of tubercle bacilli. Although this lymph has not yet proven to be the great boon an anxious world hoped for; and although many cases have terminated most disastrously which have been

subjected to its treatment, it has in other cases demonstrated a prompt curative action such as could not be claimed for any other agent ever used in the disease.

Autopsies were sufficiently plentiful in those who had been treated to demonstrate without further experiments upon healthy animals, which has since been done, that the action of this lymph upon the healthy tissue was closely analogous to what we consider the process of the disease itself.

Dr. Schweinitz's recent experiments at Washington upon hog cholera were also in the line of Koch's, and were, as the doctor himself says, a practical continuation of the experiments of Drs. Salmon and Smith in 1887.

He used the ptomaines and albumins, or as he termed them, the sucholo-toxins and sucholo-albumin from the culture liquor of the bacteria of hog cholera, and these separated and sterilized he injected into guinea-pigs to the amount of 0.05 grammes, which in most instances did not produce serious results; these animals were afterwards inoculated with .10 c.c. of hog cholera virus, and at the same time, checks, or animals which had not received this preventative treatment were inoculated with an equal amount of the same virus; of the fourteen checks that were used all died with characteristic symptoms of the disease, while but two of the seventeen guinea-pigs previously inoculated with sucholo-toxin or sucholo-albumin succumbed, and these two showed a much more protracted resistance to the disease.

A pure chemical compound prepared synthetically in the laboratory was then tried with three guinea-pigs, which were afterwards inoculated with the virus, two checks being used which promptly yielded up their lives to the cause of science, while one of the three guinea-pigs previously treated lived to be sacrificed to some future experiment.

Of the exact nature of sucholo-toxin or sucholo-albumin we are not acquainted, but we do know that in larger doses it produces rapidly fatal effects, and with symptoms and lesions not dissimilar to the disease which Dr. Schweinitz thinks it may cure.

Gibier may explain the principles of anti-rabic vaccination, as first advocated by Pasteur "as a phenomenon of cellular memory," but had he made an honestly careful study of Hahnemann's *Organon*, he might have found an easier and more correct explanation. Pasteur obtains his anti-rabic virus by trephining with antiseptic precautions the skull of a healthy rabbit, and with a hypodermic

needle, injecting under the dura mater a very minute quantity of the cerebro-spinal fluid of an animal that has recently died of hydrophobia; the wound is then dressed antiseptically, and as soon as possible after the death of the animal, which usually occurs about the tenth day, the cord is removed and suspended in a jar by a sterilized silk thread, the air of which having been rendered extremely dry by potash now absorbs a very large proportion of water from the cord and prevents it from undergoing putrefactive changes; originally the cord was left in this flask from twenty-four hours to fifteen days.

The material from the cord that had been left for fifteen days, having almost or completely lost its virulence; the one-day cord remaining nearly as virulent as the cord which had undergone no vesication.

His method of inoculation is to take fragments of different cords beaten up with twice its volume of sterilized bouillon, and beginning with the older cord, each day using the cords of more recently deceased animals. Pasteur's first human patient was a boy aged nine years, by the name of Joseph Meister, who was severely bitten by a dog known to be rabid on the day previous to commencement of the treatment (July 4, 1885). For every injection that was made into the child, a corresponding one was made into a test rabbit, and it was found that the five rabbits inoculated with the first five injecting materials had no hydrophobia, while the other eight succumbed to the disease. The boy recovered and is still living. I do not think any unprejudiced person can doubt the great efficiency of Pasteur's method of treatment, even although it is accomplished by means of an agency capable of producing the disease itself. If the statistics of the Pasteur Institute, which in 1886 showed a mortality of 13.4 per thousand out of 2682 cases treated, or a mortality of 5.4 per 1000 in 1889, are not convincing, the single instances recorded by Bates should deeply impress every thinking mind.

"Thirteen men and thirty animals—cattle, horses, pigs and dogs—were attacked by rabid wolves; of the thirteen men so attacked, twelve came to Bucharest for treatment, and all of them recovered except one, whose head was fearfully torn and lacerated by the fangs of a wolf; the thirteenth man died of hydrophobia. A very significant fact was, that every one of the thirty animals succumbed to typical hydrophobia."

But whatever doubts there may arise as to the merits of his treatment of hydrophobia, there can be none as to the success attending

his homœopathic treatment of anthrax, as there can be no doubt that anthrax is a disease of bacterial origin; and this immunity is obtained by what he terms "modified anthrax bacilli;" in other words he has secured, not the "*idem*" but the "*similia*," which introduced into the system produces symptoms and pathological lesions similar to those of the disease treated.

In truth, if Pasteur is a physician, he should be elected to membership of the American Institute of Homœopathy for the patient but brilliant, unconscious confirmation of the truth which Hahnemann promulgated.

But the object of writing this paper is not the glorification of homœopathy or the endorsement of the methods of treatment referred to; it is rather to suggest to your minds the fact that we have at our command certain agencies in the treatment of disease, the potent vigor of which under a more careful homœopathic application we scarcely can estimate.

It would hardly be policy now to laugh at our nosodes, but tuberculinum, psorinum, variolium, and a few others which are in use form but an insignificant number of those available for use, and are in themselves compound products capable of sub-division and more accurate application. The facts are, that in bacteria, and in the varied products of their growth and death, in the ptomaines, and leucomaines, in the tox albumin, in the multitudinous ferments, whether introduced as a live product or sterilized, and except in a pathogenic sense, inert matter, we have substances that more profoundly disturb the normal condition of the body, and produce morbid symptoms and pathological changes more closely allied to those evoked by disease itself, than we have in any other drugs in the *materia medica*. As I have attempted to show, these substances have apparently been most successfully applied in the treatment of disease when administered according to the principle of *similia*, and now it seems the time has arrived to extend their field of usefulness. Too much praise cannot be bestowed upon the indefatigable labor of bacteriologists in the separation and identification of the different forms of bacteria, and in the analysis and classification of the varied products of their growth; but higher praise will be theirs who succeed in using the knowledge thus gained in the control of disease.

We should not deery or ridicule the experiments of bacteriologists, because no unfailing cure has been discovered—probably none ever will be.

We must, necessarily, sift a huge mass of the dross of error to

secure the pure gold of scientific truth. A Pasteur, a Koch, or a Lister, may be the fortunate ones in finding the larger nuggets and the richer veins, but so long as "pay dirt" is in sight, let us not relinquish the task, for the slowly accumulating grains may be in the aggregate of more value than the largest nugget.

FREE DISPENSARY ABUSES.

BY THEODORE L. CHASE, ESQ., PHILADELPHIA.

PHYSICIANS practicing in large cities are coming to realize the serious injury resulting to the profession through the increase in number, and extending field occupied, by the free dispensaries established in their midst. The original purpose of these organizations, viz., relief of the poor, has been entirely lost sight of, and, at the present time, a large proportion of their visitors are persons who are amply able to pay for medical attention. An ignoble competition exists among them as to which institution can attract the largest number of patients, and those who lay claim to having treated three hundred a day, feel immense superiority over the smaller concerns that prescribe for only one hundred and fifty daily. When this ambitious desire to gratuitously treat disease, and furnish free prescriptions for the same, became apparent, it did not take long for the public, as the saying is, "to catch on," and any one disposed to make an investigation of dispensary work will be convinced that at least one-third of the patients are people in comfortable circumstances, and not infrequently there are some, bearing unmistakable evidence of wealth.

It is not very long ago when the physicians of Baltimore felt compelled to take united action against the dispensaries in that city, particularly the one connected with the Johns Hopkins Hospital, for it had become a fashionable fad for ladies to ride in their carriages to the Johns Hopkins dispensary to be examined for their complaints and prescribed for free of charge. It prevailed to such an extent, that the physicians of that city felt its influence in their practice, and although, at this time, the results are not all that might be desired, it is their purpose to use stringent measures for counter-acting the evil.

The physicians of New York city have, for a long time, been dissatisfied with the abuse of the privileges afforded by these institutions. They complain that the dispensaries have habitually extended their practice far beyond legitimate limits by treating thousands of patients not entitled to charity. These complaints are justified by facts, which the dispensaries have never denied. Some efforts were made to remedy the evil, when several of the larger dispensaries determined to exclude all applicants who could not prove that they really were too poor to pay a physician's fee.

The movement failed through the jealousies of the smaller dispensaries, that depended upon the patronage of wealthy persons for their support, and, as they made periodic appeals to the charitable public for contributions, it became a necessity of their existence to show as large a number of patients treated as possible. The result has been, that competition has increased among the dispensaries, the evil has grown, and last year the fifty hospitals and seventy-two dispensaries of that city treated 550,000 patients, or about one-third of the population of the city.

Some months ago the Vanderbilt Clinic, the dispensary connected with the College of Physicians and Surgeons, posted a notice to the effect that persons apparently well able to do without charity would be referred to the Charity Organization Society for investigation. This plan was followed by other large dispensaries, but it did not, to any appreciable extent, reduce the evil.

Through the abuse of this system New York physicians have suffered so seriously in their practice, that radical measures are now being taken to confine dispensary treatment strictly to the poor; and the Medical Jurisprudence Society, at its last meeting, appointed a committee to prepare a bill, which will be presented to the next legislature, making it a misdemeanor for an individual to obtain medical treatment by fraudulent representation. One of the physicians, who read a paper on that occasion, said: "Investigation has shown that fully half of the applicants for medical charity are undeserving of it. This estimate is based on the supposition that an income of \$500 a year lifts an individual in this city outside of the pale of charity. Another thing investigation shows is, that at a low estimate 20 per cent. of the applicants at dispensaries make false statements about their condition in life, and many of them give fictitious addresses, so that their falsehoods cannot be brought home to them. For example, a mechanic that I know, who assured the doctors that he only earned \$500 a year, and supported a family,

was proved to have an income of \$1200, and property besides. There are hundreds of such cases on record, and, of course, dispensaries cannot investigate every case. Most dispensaries treat practically all who apply, and this system makes a farce of charity. The more I consider the question, the more I believe that the law only can bring relief. It is a misdemeanor to obtain property under false pretences, and why should not the rule work in medical treatment? My idea of enforcing such a law would be something like this: Let every person who applies at a dispensary for treatment sign a statement giving his true address, the number in his family, how many members of it are engaged in making money, and the total income of the family. If there are reasons why, in case the income is larger than \$500, or thereabouts, he should, nevertheless, receive free treatment, let him state them. Let him also understand, that, if his statement is shown to be false, he can be prosecuted under the law. I believe this plan would cure the abuse."

The number of dispensary patients in Philadelphia is about the same in proportion to the population as in New York. Thirty-two dispensaries treat yearly 299,520 persons, a large percentage of whom are able to pay. The number of free dispensaries here is increasing rapidly, and the impositions practiced by patients are numerous and of a varied character. It often occurs that persons, although aware that none are refused treatment, will array themselves in threadbare garments, in order not to be too conspicuous wearing their accustomed dress. Recently, a lady with two children visited a dispensary, and one of them was prescribed for. She was recognized by a person present as one of his neighbors who occupied a house at a rent of \$55 per month, handsomely if not elegantly furnished, a piano in her parlor and other things to correspond.

Another dispensary was visited by a lady and her half-grown daughter, and was given a prescription for the latter, comprising an expensive remedy. When it was taken to the druggist, he said to her, "This medicine is costly, and I will have to charge you twenty-five cents for it." "Oh! replied the patient, "I thought the medicines here were supplied free." "They are," responded the druggist, "except in cases where the medicine is very costly." "Well," said she, "can't you let me have it without payment? I have no money." The druggist told her she could not, and the two females left. It was, however, but a few minutes when the younger one returned and presented a twenty-dollar bill out of which to pay the twenty-five cents for medicine.

In the same dispensary a man was known to resort thither for treatment during a period of nearly two months. His dress, manner and assuming ways indicated plainly that he would probably feel insulted if one should address him in so many words as a charity patient. The same person was seen one afternoon seated in a hansom, with a bouquet in his buttonhole, driving his family out to the park.

Every day in the week females visit our larger dispensaries arrayed in garments of costly material, some in sealskin sacques, others wearing diamonds, presenting the characteristics of persons not only in comfortable circumstances but able to support an appearance of affluence. One of these once remarked that it was the duty of dispensary managers to have a library from which patients could take books and thus occupy their time while waiting.

This system of indiscriminately treating all who apply at dispensaries is wrong, and should be promptly corrected. It is calculated, indirectly, to lower the standard of the profession. Young physicians, who commence practice in large cities, find the dispensaries their competitors, and from dire necessity are sometimes compelled to use means for establishing themselves that they would under more favorable conditions feel scrupulous in adopting. Our medical colleges are not beyond criticism in this connection. A young man selects one of them in which to prepare himself for the practice of medicine. He pays his matriculation and course fees, making perhaps great sacrifices to meet his necessary expenses until he graduates. It is his desire to commence practice in the city where he obtained his diploma. Now, the question arises, does his alma mater give him the moral support to which he is entitled; or does she, speaking plainly, through her actions say: "My son, it will be better for you to settle in some hemlock district; you will not succeed under the shadow of our walls, for we give free treatment and medicine to all who apply, whether millionaires or tramps, and under such conditions, if you exact a fee for your professional services, you will most probably wait expectantly in your office, until you become oxydized by time."

HERPES ZOSTER OF THE MUCOUS MEMBRANES.—Henri Fournier believes that herpes zoster of the mucous membranes is not an infrequent affection, as he has seen three cases of this variety of the disease in the past three or four years. In all three cases the region supplied by the trigeminus was affected. In one of the cases the herpes vesicles were located upon the mucous membrane of the left cheek; in the second case upon the conjunctiva of the right eye; and in the third case on the left half of the tongue.—*Monatsh. für prakt. Dermatologie*, Bd. 13, No. 8, 1891.

A CASE OF CEREBRAL HYPERÆMIA OCCURRING DURING THE MENOPAUSE, WITH REMARKS.

BY W. DULANY THOMAS, M.D., BALTIMORE.

THE subject of the menopause, or the "change of life in women," is one which receives but little attention in medical literature. Most of the works on the "Diseases of Women" pass this article by unnoticed, while others, deeming it necessary to say something, treat of it, but only superficially.

This period in woman's life is a very unsatisfactory one; its symptoms are variable, and their name legion. What may be present to-day may be absent to-morrow, and what may be an insignificant symptom now may shortly develop into great importance.

It is not strange, then, that the woman so afflicted looks forward to the time when nature shall cease afflicting her. Although she steps over the border-line of blooming womanhood to that of old age, wrinkles do not come immediately, and the unmistakable appearances of advanced life are not at once depicted with certainty. She is not annoyed and worried by anticipating her monthly flow, coming, as it so frequently does, with pain and mortification; and she acquires a more hopeful aspect of life. Like the young girl at puberty, the body may assume more plumpness, and the once fair face, the admired of all admirers, may not only resume some of its former beauty, but be even more attractive. This delay in the manifestations of approaching senile life, is brief; and while the evidences of the decline of life come on slowly, she is none the worse—except in the passage of time—for having passed this period of her life.

Let me here quote from that distinguished author, Dr. Charles D. Meigs, who, speaking of this change in woman's life, says:

"There is something melancholy in the consciousness of a decadence of the constitution, that must attend the final cessation of the menses. The subject of such a conviction is obliged to admit that she has now become—what? an old woman! Henceforth, what has she to expect save gray hairs, wrinkles, the gradual decay of those physical or personal attractions which heretofore commanded the flattering homage of society—the slow augmentation of the weight of existence—when the grasshopper becomes a burden—when the keepers of the house shall tremble, and they that look out of the windows shall become dim; the pearls of the mouth are become

tarnished, the haylike odor of the breath is gone, the rose has vanished from the cheek, and the lily is no longer the vain rival of the forehead or the neck. The dance is preposterous; and the throat no longer emulates the voice of the nightingale. . . . To be sure, religion can bring its consolations, its hopes and its triumphs—for religion can make us triumph over death and the grave, robbing them of their sting and their victory. Still, human we are, and we shall be human while the clogs of mortality still hinder and bind us.”

Before proceeding further, let us briefly consider the nervous supply of the organs presiding over menstruation and ovulation. Placed as they are, in the pelvic cavity, a perfect network of nerves and nerve plexuses surround them. The spermatic ganglion envelops the spermatic vein and artery, and is distributed to the fundus of the uterus and to the ovaries. The principal nerve supply is derived from the inferior hypogastric plexus—otherwise known as the pelvic plexus. This gives off branches to the vagina and uterus. The uterine branches spring from the side of the pelvic plexus, lying between the folds of the broad ligaments until they reach the cervix, when their course is upward, accompanying the branches of the uterine artery and entering the substance of the organ with them.

Reflexly, symptoms are referred to the heart, circulation, liver, stomach, and lungs, and last, but not least, the head, by alterations in the generative organs, be they congestion, anæmia, hypertrophy, or atrophy; ulceration, foreign growth, displacement, or rupture. Many of the hystero-neuroses are dependent on one or more of these changes, and not a few women are transferred from one doctor to another, and treated symptomatically, until some one has courage enough to submit the sufferer to a vaginal examination. I have under my care, at present, a lady who has gone the rounds of several physicians (not excepting those endowed with magnetism), and been treated symptomatically, and in whom I am quite confident some uterine or ovarian trouble lurks. The irritation of the ganglionic nervous system, the result of alteration in these organs is readily conveyed, as we have just seen, to the organism at large, sometimes by way of this channel, or course of nerves affecting certain parts in close apposition; at other times, some more distant part. One of the most prominent symptoms is a relaxation of the vasomotor system, by which flushes, swelling, heat, or redness of the surface ensue; or, perhaps, contraction of the vessels, causing chilliness, or a well-marked chill, which may possibly be the explanation of the condition experienced by the patient whose case I shall presently re-

late. Influence may be had on the pneumogastric, and palpitation and nausea result. None the less prominent or important are symptoms referable to the brain. All works on insanity speak of this form of mental defect; although not necessarily marked, yet there may be the lurking tendency, ready, with slightly increased provocation, to spring forth with all its wonted violence.

The changes may not be so prominent, nevertheless, there will be inability to compose the mind by sleep, notwithstanding the desire be great. Should sleep intervene, it is characterized by worried or frightful dreams, and an inability to remember but few, if any, of the particulars. These symptoms are characteristic of cerebral congestion. In the case just alluded to, supposed objects have been seen, such as her father and mother, deceased, cats and mice and other hallucinations.

The symptoms of women who are approaching, or who have reached this time of life, are treated, as a general rule, too lightly. They are told that all their symptoms are due to changes going on in the generative organs and will disappear as soon as these changes are completed. Very encouraging, I assure you, to the patient who leaves your office about as wise as when she entered it. We might as well inform the patient suffering from malaria, that possibly he will be benefited when cold weather sets in, when he cannot receive further supplies of the poison, without giving the indicated remedy to prevent the manifestation of that already in his system.

The menopause is not to be considered as an inoffensive affection, and the treatment accordingly directed to the symptoms alone; but as the turning point in a woman's life, when she will become more earnest and zealous in her sphere, provided she is tided safely over this tempestuous portion of her life's journey.

It may not be necessary to submit the patient to a vaginal examination in all cases; but should the symptoms of the disorder increase, rather than decrease in severity, then it becomes proper for us to ascertain if any trouble exist in the genital organs. She may long have ceased to menstruate, and be suffering from vague nervous symptoms not to be relieved by internal medication. Inspection reveals the uterus hypertrophied, and dilatation, a polypus large or small in size. This acting as a foreign body sets up an irritable condition of the uterine nerves, which acting reflexly upon other organs accounts for the alteration in function there experienced. If a polypus or other foreign substance be not found, a carcinoma of the

cervix may be observed; if not of too long standing relief, or possibly a cure afforded. The woman may have been experiencing for some time past frequent and excessive menstruation. She recognizes the fact of being at, or near, the menopause, and considers her symptoms due to the change. So may her physician if he takes not the trouble to dilate. If, however, he thinks best to expose the inner surfaces of the uterus, fungous granulations may be appreciated which when removed by the curette allow the process of alteration to go on normally, and the woman to experience more comfort than formerly.

It is customary for women to expect the change of life to appear when they shall have reached the age of forty-five.

Upon this subject M. Brierre de Brismont remarks as follows:

"It has been said in a general way, that the cessation of the menstrua takes place about the forty-fifth year in this country—a little sooner or a little later. The fact is true; but we believe that a better appreciation would be made by presenting a table indicating the different periods of the critical age. We have here collected 181 cases of women indicating the age at which the menses had ceased, and here are the results:"

At 21, 2	At 34, 4	At 42, 7	At 50, 12
24, 1	35, 6	43, 4	51, 4
26, 1	36, 7	44, 13	52, 8
27, 1	37, 4	45, 13	53, 3
28, 1	38, 7	46, 9	54, 5
29, 1	39, 1	47, 13	55, 2
30, 3	40, 18	48, 8	56, 2
32, 2	41, 10	49, 7	57, 2
	At 60, 1		

Thus it will be observed that the menopause may appear at a very early date, though the larger number occur at the 44th, 45th, 47th and 50th years. While we have pregnancy in girls at the ages of 13, 14, and 16 years, and even in some cases before the menses have made their appearance, so may we have a child born to those well stricken in years. In Genesis, xviii. chap., 11th and 12th verses we read: "Now Abraham and Sarah were old and well stricken in age; and it ceased to be with Sarah after the manner of women. Therefore Sarah laughed within herself, saying, after I am waxed old shall I have pleasure, my lord being old also?"

In a case reported by Bernstein and quoted by Orfila, "the function appeared at 20 and she menstruated until her 99th year. Her first

child was born when she was 47, and her seventh and last when she was 60." Dr. Taylor in his work on *Medical Jurisprudence*, cites the following reported in the *American Journal of Medical Science* (January, 1845, page 107), "In a nun the menses ceased at 52; at the age of 62 they reappeared, and so continued regularly, until she was last seen at the age of 73." "In another instance, a nun, aged 90, had regularly menstruated from 15 to 52. The menses then ceased, but they reappeared at the age of 60 without pain, and had occurred regularly every month since that date."

Neuermann has presented a table showing the advanced ages of life at which children have been born. "Out of 1000 cases in 10,000 births, he found that 436 children were born by females at the ages respectively :

Of 41 years,	101	Of 48 years,	8
42 "	113	49 "	6
43 "	70	50 "	9
44 "	58	52 "	1
45 "	43	53 "	1
46 "	12	54 "	1."
47 "	13		

In the case about to be related, menstruation commenced at the age of 15; the subject is now 48 and the menses still occur at quite regular intervals.

The case is as follows :

Miss L., aged 48, commenced to menstruate when 15 years old, amount normal; duration three to five days; dysmenorrhœa a more or less prominent symptom.

Some years past, while lifting a heavy article, something was "felt to slip," and the left ovary upon examination was found displaced. It was placed *in situ*, and no further trouble experienced. Her health up to the present illness has been good, with the exception of single attacks of intermittent fever and rheumatism. The latter affected the heart, leaving as a result a pre-systolic mitral murmur.

April 18, 1887, while urinating, numbness of the right side of the body and face supervened, together with partial blindness, restricted to the right eye.

After walking from the water-closet in the yard to the house, a severe chill set in which lasted twenty-five or thirty minutes.

During the chill I saw her. The numbness of the right arm and

leg was well marked, and continued so for about an hour, when it slowly disappeared, only to reappear subsequently in a less degree. This symptom proved to be a very annoying one, obliging her to remain at home even after the more urgent manifestations of the disease had disappeared. During the progress of the chill she was put to bed and warmth applied, which promptly effected its intended purpose. Her face was flushed and hot, and the carotid arteries throbbed forcibly. Cold cloths were applied to the neck, temples, and back of head, and relief given.

Returning in the afternoon I found her more comfortable, though in a rather confused state of mind. Objects in the room did not appear natural, and a "boiling sensation," as she termed it, was felt in her head. I administered a very moderate dose of potassium bromide, which had scarcely entered the stomach before she became extremely nauseated—a mere co-incidence, I judge—but the potash had a fair share of the blame, and the medical attendant as well by some would-be wise friends of the family. Her condition for some time was serious. Brandy by the mouth had no effect, and it was not until given hypodermically that the pulse began to assume some volume and the respirations to return to their normal state. During this period the face was not flushed but bloodless, and the pulse scarcely perceptible at the wrist. Shortly after restoration to complete consciousness nausea and vomiting occurred, relieved by the administration of proper remedies.

Her condition next morning was slightly better, although occasional flushings occurred from time to time, with great aversion to noise and inability to remember or concentrate her thoughts upon any particular subject.

April 22d, four days after first appearance of the above described symptoms, menstruation occurred. Instead of occurring every four weeks, this had for the past year come on every second week, indicating very likely a commencement of the trouble. No decided relief from the head symptoms was felt at this time by the appearances of the menses.

May 12, 1887, her symptoms became worse. She was subject to syncope, together with difficult respiration and inability to articulate, but conscious of what was going on about her. These attacks lasted about five minutes. Symptoms referable to the brain, for the remainder of the day would, however, be augmented. After experiencing one of these attacks in my presence, she became violently convulsed, the convulsions at first being tonic, and latterly, clonic.

Morphia hypodermically and cold to the spine had but little calming effect, and at one time her condition appeared precarious.

Apparently not getting much better and the convulsions having continued now, at intervals, for ten hours, she was leeches at the back of the neck. This produced the effect desired; during the night she slept tolerably well.

The day following, the convulsions were slight and were kept well under control. It is to be supposed this alteration in the symptoms heretofore explained was merely a reflex manifestation of the changes going on in the genital organs. Up to the time the convulsions occurred she had not had her regular monthly flow, which was due, and it was not until four or five days afterwards when the menses appeared, that any marked improvement in her condition was appreciable. Cardiac distress was a prominent symptom, being less severe when the hyperæmia of the brain was increased and *vice versa*. Strophanthus θ acted well in allaying the weakened condition of the heart.

From this time on she has continued to improve. At her menstrual periods, which are *quite* regular, she suffers more or less from dysmenorrhœa and symptoms referable to brain congestion. While this symptom (congestion) was most severe much benefit was given by the inhalation of sulphuric ether.

It will be noticed in the foregoing case that the first marked symptom of cerebral hyperæmia was experienced during the act of micturition. True, it is, that congestion of the brain may be due to the strain consequent upon the act of defecation, such a case having come under my notice in my own family; but it is hardly possible, I think, that there could have been so much *difficulty* in urinating as to produce such symptoms, although this might have been an exciting cause, when the brain only required the slightest provocation to induce a complement.

She had for some days previous been exceedingly worried over some family affairs, and this in addition to the expected monthly flow which had been delayed, was more than likely the direct cause.

Premonitory symptoms may precede an attack of cerebral hyperæmia. Thus, there may be vertigo, and an uncomfortable feeling in the head not amounting to a true cephalalgia; noises in the ears, and flashes before the eyes; irregular cardiac action and a flushed face; numbness of the surface with tonic and clonic spasms may supervene. That this condition of the brain may be induced suddenly, is proved by a case selected from Dr. Hammond's work on *Cerebral Hyperæmia*.

"M. S——, a young lady, aged 19, and without notable predisposition to neurotic disturbances, was deeply chagrined at not being invited to a ball at which she had confidently anticipated being present. While talking the matter over with some friends, she suddenly experienced a severe pain in the head, vertigo, noises in the ear, flashes of light alternating with darkness, and violent palpitation of the heart. At the same time a peculiar thrilling sensation was felt throughout the body, especially on the left side. These symptoms continued with great intensity, notwithstanding that stimulants and antispasmodics were administered in large quantities by the physicians called to attend her. During the night every attempt to turn over in bed was attended with vertigo and palpitation of the heart. For over a year there was little improvement."

The inability to fix the mind upon any definite subject, accompanies an increase in the severity of the symptoms. In the case related at length, an attempt to read was accompanied by increased cerebral congestion. This symptom was, however, relieved by proper glasses of which she was in need.

Physical symptoms of disordered cerebral action are,—heat and fulness of the head; a plugged sensation in the ears, heaviness of the eyes, and a whirling, boiling, or singing sensation in the head. In the case of Miss L., loud reports are often heard, after which the ringing of innumerable bells are heard; and the disagreeable sensation of fulness in the head, which before the report was marked, immediately lessens in severity or ceases altogether.

A careful diagnosis should be made between cerebral hyperæmia and cerebral anæmia. Both are characterized by headache, vertigo, loss of memory, numbness, mental confusion, and noises in the ear. A careful diagnosis becomes more imperative when we perceive all these symptoms are increased if the medication is wrongly applied. In congestion there is drowsiness, a contracted pupil, a throbbing of the temporal arteries, and a flushed appearance of the face. On the other hand in anæmia there is wakefulness, dilated pupils, a weak, frequent pulse, and a pale face. A bellows murmur may be heard at the base of the heart, and in the veins of the neck. The ophthalmoscope and aural speculum may come into requisition, if an uncertainty in the diagnosis yet remain.

The treatment of this case consisted principally in the application of cloths wrung out of ice-water to the carotid and temporal arteries, the internal administration of belladonna 2x, gelsemium 1x, and bryonia 3x, and the inhalation of sulphuric ether, which the patient

administered herself by means of a vial containing the anæsthetic applied to the nose, only a few inspirations being necessary to relieve the congestion.

At the present writing the patient is in moderately good health, with the exception of recurrent attacks of headache of the congestive type from any undue physical or mental exertion.

JOTTINGS FROM ACTIVE PRACTICE IN OLD ENGLAND.

BY ROBERT S. COOPER, M.D., LONDON.

(Physician, Diseases of Ear, London Homœopathic Hospital)

(Concluded from page 37.)

WHEN I bring forward these remarkable cases of cure by high dilutions, it must not be supposed that I commit myself to the use of high dilutions alone; all I do commit myself to is a position of absolute impartiality so far as the high dilutions are concerned. It annoys me beyond measure to hear the idiotic ribald laugh at our Society's meetings when a well authenticated case of aggravation or cure with a high dilution of a remedy is narrated, the laugh coming perhaps from a practitioner who would not trouble himself to cross the road to see a case of cure or of aggravation with a high potency.

I have referred to old David Wilson, of Brook Street, now alas! among "the late lamented." When doing Mr. Campbell's work as House Surgeon at the London Homœopathic Hospital in 1865-66, I used frequently to wend my way on a cold winter's morning to Wilson's Dispensary, held at his own house in Brook Street, a most unusual institution to be in connection with the home of a fashionable consultant. The old man used to begin his work at half past five or six o'clock in the morning, and well do I remember hearing a patient, one of many, say she had travelled all night to see him. And on my calling upon Dr. Wilson some three months before he died, he assured me the patients used to begin coming at 2 o'clock in the morning, and that it was necessary to have for them a free access to the house from the back and fire alight all night. So noticeable was it that the police more than once cautioned him his house would be robbed were he to leave it open like this. To the

honor of the poor folk that attended, let me say that such an occurrence never once took place.

The matter demands mention from the fact that though I often went to see the old man prescribe, I never yet met any of those men present who are such virulent opponents of high dilutions, and who were loud in professing to have impartially and carefully investigated the relative merits of both forms of drug powers. I have attended the practice of many hospitals and dispensaries in my day, and witnessed the doings of many splendid operators and prescribers, but never did I behold a grander sight than that of the old man coming down in his dressing gown on a cold winter's night simply to work out the actions of his remedies and at the same time to relieve the sufferings of the poor. This was the more meritorious as the time occupied in dispensary work used to extend far into his usual working day, and thus take from the hours that would otherwise have been, literally, golden. Well may it be said that David Wilson had

"A frame of adamant, a soul of fire,
No dangers fright him, and no labors tire."

Pity indeed it is that while such a life may well remind us of how sublime a life may be, it does not as well teach us to leave behind us any very marked "footsteps in the sands of time;" for of late years he eschewed most religiously contributing to journals, and never issued his long promised work on the *materia medica*.

This is a matter of great regret to myself and to most of his friends; in this respect and in this only, he proved himself unworthy of Hahnemann.

I have referred to a case of *ozæna* cured with the 200th of nitric acid by the late Dr. John Epps; the higher powers of nitric acid are undoubtedly of great efficacy in this affection, especially in very obstinate forms of it, but following upon it comes with almost equal effect benzoic acid in the 30th.

Considering the pathology of *ozæna* it is of course hard to understand how any case can be cured. One cannot help asking what became of the carious bone in the example of cure given; was the dead bone reabsorbed or did its particles remain buried in the surrounding living structures, the former ceasing to irritate?

TINCTURE OF BRYONIA in five drop doses four or five times a day is a simple and effective remedy for the condition known as irritation of the vesical neck. The bandage is also useful during pregnancy.—Dr. Boldt, *American Journal of Obstetrics*, July, 1891.

ANEURISM OF THE ABDOMINAL AORTA—A CASE.

BY WESTON D. BAYLEY, M.D., PHILADELPHIA.

J. M., æt. 44; single; came under my care on April 9, 1891. Broken down by alcoholic and other excesses, he had the appearance of being much older. He had been otherwise healthy, excepting for a very indefinite attack of "malaria" four or five years ago.

Of late he had been losing flesh rapidly, and, besides the emaciation, there was a peculiar ashy color of the skin. He complained of paroxysms of abdominal pain coming on at irregular intervals, but usually following stool. The bowels were costive—possibly the result of habit, as he avoided stool because of the subsequent pain. Appetite was poor, but food and drink caused no discomfort. The temperature was normal, and, taken at irregular intervals, continued so throughout the period of illness.

Upon physical examination, the abdomen was found hard and tympanitic. There was an area of percussion dulness on the left side from the ninth rib downward to a point slightly below the umbilicus, extending anteriorly to within two inches of the median line, and lost posteriorly in the dulness of the spine. This tumor had a hard, dense feel, and was the seat of feeble pulsation, giving the impression to the hand of aortic throbbing communicated through an hypertrophied spleen. No murmur could be heard in any part of it. The liver was not enlarged. The heart's action was weak and irritable, but no ascertainable enlargement or valvular change. Urinary examination negative.

At this time the case was regarded as one of splenic enlargement, possibly of a cancerous nature.

Large enemata of hot water every second day were ordered and arsen. iod. 2x given. Morphia was required to control the severe pains, which he described as sharp and burning in character. During the three following weeks cachexia and pain increased; the pulse became feeble, rapid and dicrotic, and at the end of that time he was unable to move from his chair. The feet and legs became immensely œdematous, the water oozing through ulcerated abrasions of the skin. Fluid could be detected in the abdomen. Pulsation in the tumor-area became more perceptible, but still was not marked. During this time morphia was a necessity, and the quantity given

had to be increased. I now felt that my earlier diagnosis was incorrect.

Digitalis gtt. iij. every two hours and enforced recumbency rid him of the dropsy in a remarkably short time. This remedy was continued because of its favorable influence upon the pulse, until death, which occurred on June 5th.

Owing to family prejudices, autopsy was limited to the abdominal cavity.

The amount of fluid in the abdomen was slightly in excess of normal. Drawing aside the small intestines, a mass of retro-peritoneal clots came into view. The left kidney was quite superficial, being pushed forward by a growth, to which its capsule was adherent. This mass extended downward from the diaphragm to the iliac fossa—superficial in its upper extent, but covered by small intestine below the navel-line. Its walls were thick, dense and bound in position by firm adhesions. Emptying out a large number of hardened clots, its lower portion was found to be sacculated and resting against the iliac tissues. Above, it joined the aorta, by a constricted neck, immediately below its emergence from the diaphragm. Vertebral absorption had taken place, and this was responsible for the rupture, roughened edges of bone having first thinned out, and finally penetrated the sac.

The spleen was of natural size, slightly flattened on its lower border and under surface. Kidneys, stomach and liver appeared normal. The pancreas was larger and of firmer consistence than I have seen it, and there were several enlarged lymphatics in its vicinity. The descending colon was narrowed at its upper portion, firmly pressed upon by the sac at its middle, and the lower part, together with the sigmoid and rectum, was full of hardened feces.

The interesting features of this case were the almost entire absence of pulsation, the inability to discover a bruit, the firm, dense feel of the tumor, and the position—all of which suggested splenic growth rather than spinal abscess or abdominal aneurism.

PUERPERAL ECLAMPSIA ASSOCIATED WITH THE URIC ACID DIATHESIS.—In a paper read before the New York State Medical Association, Dr. George E. Fell related the history of a case and raised the question, What had this diathesis to do with the eclampsia? He detailed some experiments of Semola, going to show that in animals this condition could give rise to convulsions. He also cited another case of a woman who, in the early months of pregnancy, began to fail rapidly in health, coincident with the appearance of symptoms of the uric acid diathesis, but who was rapidly restored to health by alkaline treatment, associated with daily irrigation of the bladder. From this he concluded that still another reason had been found for the physician's carefully watching over his patients during pregnancy.—*New York Medical Journal*, November 28, 1891.

CORRESPONDENCE.

HALF A CENTURY OF MEDICAL WORK.

DEAR DR. VAN BAUN: You asked me for a photograph of myself for the *HAHNEMANNIAN MONTHLY*, and I cheerfully consented to send you one as soon as one of our rare glimpses of sunshine should allow me to sit to the solar artist. Now that you have got the portrait, you ask me to send you "a lovely sketch of my life," to match the picture, I suppose. But that is a very different matter, and a request not nearly so easy to comply with. In the course of my long career I have written many sketches of the lives of different homœopathic worthies, but have never yet attempted one of my own life. The memoirs I have written of others I have always been able to round off and give them the proper artistic finish by recording the death of their subjects, but in the case of my own life by myself you must not look for such completeness, for, unlike Moses, I am not able to tell you my exact age at death; still less can I boast like him that when the end came "my eye was not dim" (alas! I have to wear spectacles and have a most pronounced annulus senilis), nor my "natural force abated." I might, indeed, say, like Caleb, the son of Jephunneh, that I am as strong this day as I was when forty years old, but that would convey no information to you, as you do not know how strong I was at the age of forty. As you *will* have my life, written by myself, you must take it in its necessarily incomplete state, and with all the imperfections that must attend the work of the dim-eyed and no longer youthful writer. I would naturally feel an objection to writing my autobiography for an English periodical, because, as every one knows me here, they would be able to compare my portrait of myself with their own observations, and as no power can "the giftie gie us to see oursels as ithers see us," they might find discrepancies betwixt the self-drawn picture and their own conceptions of it. This objection does not apply to furnishing a self-portraiture to an American periodical, for as I am personally unknown to the great majority of its readers they will not be able to cavil at the possibly defective likeness of my sketch.

I have, as I have said, never before attempted autobiography, so you must excuse all errors and faults inseparable from a first attempt at an unaccustomed kind of literature. The worst of it is that one

has to talk such a deal about one's self. One seems to become the centre of the solar system around which all others, great and small, revolve. I suppose it is natural that every one who writes his memoirs should feel himself the centre of creation—for the time being “the hub of the universe” like the city of Boston, Mass.—and probably this is why the big bugs of legendary lore, in course of time come to be considered as solar myths.

After this prolegomenon I proceed to my medical biography.

I was born, as I have been informed, for my memory does not go so far back, in a country house in the outskirts of Edinburgh, on St. Patrick's day, 1820. This, I hope, is the only event in my narrative which I must give on other than my own authority. My medical studies were carried on in the University and the extra-academic Medical School of Edinburgh. I took my surgeon's diploma in 1839, and as I could not obtain my university degree before I had attained my majority, I spent the intervening time chiefly in Paris, where I pursued my studies in the *École de Médecine* and the hospitals, attending the lectures and the clinical practice of Velpeau, Andral, Civiale, Maisonneuve, Louis, Piorry and others. Returning to Edinburgh in 1841 I passed my final examinations and was duly invested with the magic cap which constituted me “*Medicinæ Doctor*,” on the 1st of August of that year. After that I went to Vienna, where I passed a semester and profited by the instructions of the great medical lights of that city, among whom I may mention Skoda, Rokitansky, Hebra, Heller and Jæger. I had for fellow-students in Vienna, Drysdale, Russell, and Fisher, all well known in the homœopathic world, and Wilde (afterwards Sir William), who did good service to homœopathy by stating the truth respecting its success in the treatment of cholera in his book on Austria. We were all very sociable, and used to dine together at a favorite restaurant. Almost every day Drysdale, Russell, and Fisher were studying homœopathic treatment at Fleischmann's hospital. At that period I felt no interest in Hahnemann's system. I next spent a few months in Berlin studying eye and ear disease under Jüngken and Kramer, and organic chemistry under Simon. I then went for some months to Dublin, where Graves, Stokes, Corrigan, and Marsh were in full force. I renewed my friendship with my old chum Wilde, and visited his eye and ear practice diligently. Thus equipped with as much medical learning as I could comfortably assimilate, I set up in practice in Liverpool, where my father then resided. Drysdale, who practised there then as now, persuaded me

to look into homœopathy. In 1843 the *British Journal of Homœopathy* was started by Drysdale, Russell and Black, though there were not then a dozen homœopathic practitioners in the United Kingdom. Drysdale gave me many articles to translate from the German for the *Journal*, and I thus learnt a good deal about the new system, and gradually became a thorough believer. By Drysdale's advice I returned to Vienna to see the homœopathic practice of Fleischmann in the famous Gumpendorf Hospital. I now had for fellow-students Madden, Hilbers and Macleod. Madden and I, with our wives, lived together, and we devoted much of our time to the study of the *materia medica*; endeavoring to construct real pictures of disease from the *dissecta membra* of the provings, with but little success as may be imagined. I made the acquaintance of most of the principal homœopathic practitioners of the Kaiserstadt, Wurmb, Watzke, Gerstel, Zlatarovich, Nehrer, and many others, whom I frequently met at the society and at their social gatherings, and from whom I learnt much. At that time Vienna was in the heyday of its homœopathic fervor, and a vast deal of invaluable work was done in the way of proving new medicines and re-proving old ones. Many useful essays were also published in the periodicals edited by the homœopathic society. A few years later the representatives of homœopathy in Vienna, apparently exhausted by their effort subsided into a lethargy from which they have not yet been aroused. While their zeal lasted we must allow that they did splendid work.

On my return to this country I commenced practice in London. That was in 1845. The following year I joined Drysdale and Russell in editing the *British Journal of Homœopathy*, then commencing its fourth volume. Black had withdrawn from the editorship after the first volume. I remained editor till the cessation of the journal in 1884. Russell ceased his connection with it in 1858. Atkin joined the editorial staff in 1859, but we lost him in 1861. In 1863 Hughes became an editor, and in 1877 Hughes and I were left alone by the retirement of Drysdale. Clarke came on in 1883 to make us again a triumvirate and to assist at the obsequies of the old journal, which expired the following year. During the thirty-eight years of my connection with the *British Journal of Homœopathy* there was, of course, much work to be done, and it is for others to say if that work was well or ill done. I rather think there were some regrets at the final disappearance of this quarterly; at all events, the fact that we were entertained at a grand dinner where all the old

editors were presented with magnificent pieces of plate by our colleagues, shows that they were not displeased with the manner in which we had performed our editorial work.

During the long period, nearly half a century—*heu fugaces labuntur anni!*—that I have been connected with homœopathy, many incidents have occurred, many controversies have arisen, and many victories achieved, in which I have been more or less intimately engaged. It would exhaust your patience and weary your readers were I to give even a brief account of all of them; many of them, indeed, I have now forgotten, though a diligent search in the forty-two volumes of the *British Journal of Homœopathy*—that book of the chronicles of homœopathy—might recall them to mind. I shall only mention the most noteworthy events in which I have been personally implicated.

A few years after Hahnemann's death, in 1843, the Central Society of German Homœopathists commenced to agitate for the erection of a monument to the founder of homœopathy. Dr. Rummel, as treasurer of the committee appointed by the society for this purpose, appealed to British homœopathists for subscriptions. His appeal was liberally responded to by our countrymen, and sufficient funds having been collected, the committee announced that the monument would take the form of a statue of Hahnemann to be erected in Coethen. To many of us it appeared that Coethen was a most inappropriate locality for the proposed monument, as Hahnemann's connection with that dull little town was purely accidental and transitory. Either Meissen, his birth-place, or Leipzig, where he first publicly taught his doctrines and founded his school, was the proper place for his statue. I wrote in this sense to Dr. Rummel, but he replied that it was too late to make any change, as all arrangements had been completed for the erection of the statue in Coethen. The Congress of the Central Society of 1850 was held at Liegnitz in Silesia. I travelled thither and spoke strongly, in my choicest High Dutch, against the determination of the committee. I was told that no change of locality was now possible; the municipality of Coethen had granted a site, and the Duke of Anhalt-Coethen had promised a liberal contribution, on the understanding that the statue should be erected in his capital. In short, I was snubbed by the committee and the society, and plainly told that it was none of my business to interfere with the society's arrangements. On my return to England I brought the subject before the Homœopathic Congress which met that year in Cheltenham, and a unanimous resolution was passed by

them condemning Coethen and recommending Meissen or Leipzig as the proper site for the statue. On receiving this influential remonstrance and recommendation, Dr. Rummel wrote to me that the committee had reopened the question of the site, and in deference to the wishes of their British colleagues had determined to erect the statue in Leipzig, provided the extra expense involved in the change should be met by subscriptions in England. I made a second appeal to my colleagues, and soon collected the required funds. This settled the matter, Leipzig was substituted, and the following year (1851) the statue was unveiled amid a large assembly of Hahnemann's disciples from various countries. England was represented on that great occasion by Drysdale, Russell, W. Hering and myself. It is curious that no allusion was made by any of the speakers to the circumstances which had induced the committee, at the eleventh hour, as it were, to save the statue from sharing its original's exile in the obscure and petty capital of an insignificant principality. *Sic vos non vobis!* Coethen was not in the end deprived of a statue of its whilom guest. Dr. A. Lutze, who set up in practice there after the great reformer's departure, erected there a statue of Hahnemann (made of stucco, I believe), at his own expense. Those desirous of seeing this work of art should visit Coethen, if they can discover exactly where it is. I have been there myself, so can certify that there is such a place. But, as Lutze's statue of Hahnemann stands in Lutze's back-garden, perhaps the adventurous visitor might miss seeing it after all.

Whilst the representatives of homœopathy were in full conclave in their hall, listening to a learned paper by Dr. Clotar Müller, they were alarmed by a loud explosion, quickly followed by a still louder, proceeding from beneath the room. Naturally the first idea was that this was a gunpowder plot devised by some allopathic Guy Fawkes, and intended to blow us all into the air. The actual fact was, however, not so sensational. Beneath our hall was a shop where fireworks were sold, two boxes of which had successively exploded, without doing any damage beyond alarming us and breaking a few panes of glass. There was in the shop a barrel of gunpowder, which, had it caught fire, would have blown us into smithereens. Had this happened my memoir would have terminated here in a singularly effective manner amid a grand corruscation of sky-rockets, squibs, Catherine wheels and Roman candles. I should have ascended to empyrean heights in good company too, for many of the most distinguished disciples of Hahnemann were present

in the room, among others Stapf (of *Archiv* fame), Bönninghausen, Rummel, Haubold, Melicher, Schneider, Weber, Rückert, Veit Meyer, Clotar Müller, Rentsch, Hartlaub, Herschel, Trinks, Wolf, Gross, Bolle, Hofrichter, Caspar, Wahle (of Rome), Pabst (of Copenhagen), and that stately grandee of Spain, the Marquis Nuñez, physician to her most Catholic Majesty, Queen Isabella, who, it is said, might still be on the throne had she been contented with her physician's medical advice and refused to listen to his political counsels. F. Hartmann, though in Leipsic, was confined to his arm-chair a helpless cripple, so could not take part in the ceremony. All these champions of homœopathy have now gone to join the Master in the Elysian Fields, except Drysdale and myself. We stand like two solitary gnarled trunks in a forest where the grim woodman has cut down all our companions, and has paused to sharpen his axe in order to complete his work. No representative of American or French homœopathy was present on this great occasion. Your countrymen had not yet discovered how easy it is to cross the Atlantic from your side, and the French had not yet made up their minds to rush "à Berlin"—when they might have taken Leipzig by the way.

I had a considerable share in founding the Hahnemann Hospital and School of Homœopathy in Bloomsbury Square, with which was connected the Hahnemann Medical Society. I need not give the history of that movement. While it lasted some useful work was done. Courses of lectures were delivered to students at the hospital by Dr. Curie on Therapeutics, by Dr. J. Epps on *Materia Medica*, and by myself on the Theory and Practice of Homœopathy (my lectures were published in one volume in 1854). Dr. Curie having died, the managing committee of the hospital, all laymen, and most of them Curie's personal friends, laid their wise heads together, and finding that the hospital had no debt, resolved to shut it up, and this they did without giving the medical staff the slightest hint of their intention, so that we were amazed and disgusted to find, one day, the shutters up and bills announcing the place to be let. We were naturally indignant at this high-handed action of the committee, as the hospital was doing very good work among the poor of the neighborhood, and many interesting cases were treated and fine cures made in it. The moral to be drawn from this affair is, if you want your hospital to be a permanent institution, see that you start it with a sufficient endowment or a good thumping debt, then your managing committee cannot close it suddenly at their own sweet will and pleasure. The hospital being gone, the lectures were stopped and the

society having no local habitation, languished and died, leaving the British Homœopathic Society and the London Homœopathic Hospital masters of the field, to which we accordingly transferred our allegiance. All are now united in support of these two institutions which have gradually eliminated from their laws most of what the dissentients objected to.

In 1852 an agitation commenced among the governing authorities of the medical profession for an act of Parliament to regulate the affairs of the medical schools and colleges. The movement came to a head in 1858, when the famous Medical Bill was brought before Parliament. As almost all the leading bodies had at different times shown their hostility to homœopathy by passing resolutions against it, or by rejecting candidates for their diplomas who were suspected of leaning towards homœopathy, or who avowed their intention to inquire into the hated system, it was thought desirable to scrutinize carefully the text of the bill to see if it countenanced this persecution of the members of our school. I procured a copy of the bill, and found to my consternation that it afforded no protection to candidates for diplomas against their arbitrary rejection by examining bodies on account of their supposed or avowed preference for modes of practice differing from those of their examiners. A case which had recently occurred in Aberdeen showed to what lengths examining boards would go in their crusade against homœopathy. Mr. Harvey had already passed satisfactorily two examinations before the faculty of the Marischal College of that town. But his examiners having a suspicion that he was favorable to homœopathy, before admitting him to his final examination, sent him a letter in the name of the Professor of the Principles and Practice of Medicine, Dr. Macrobin, in which he demanded that Mr. Harvey should make "a distinct declaration that, as a man of honor, you have not practised and do not entertain any intention of practising the profession on other principles than those taught and sanctioned in this and other legally recognized schools of medicine." As Mr. Harvey refused to make any such absurd declaration, he was not permitted to complete his examinations and obtain his degree. The bill if passed in its actual form would allow any examining body to exact similar declarations from candidates, and homœopathy would thus be practically extinguished in this country. The bill had by this time already passed the House of Commons and was to be read in a day or two in the House of Lords, when, if no amendment was proposed it would become law and seal the fate of homœopathy.

No time was to be lost, so I rushed off to consult with that old tried friend of homœopathy, Lord Ebury. He fully appreciated the peril of the situation and sent for Mr. William Cowper (Lord Palmerston's step-son, afterwards Lord Mount Temple), who, as an old parliamentary hand and a friend of homœopathy, would be able to advise us in the matter. So we three conspirators sat down and concocted a clause for the bill, which would, if passed, be an ample protection to candidates for diplomas against such tyranny as that of the Aberdeen College. This clause runs as follows:

"XXIII. In case it shall appear to the General Council that an Attempt has been made by any Body entitled under the Act to grant Qualifications, to impose upon any Candidate offering himself for Examination an Obligation to adopt or refrain from adopting the Practice of any particular Theory of Medicine or Surgery as a Test or Condition of admitting him to Examination or of granting a Certificate, it shall be lawful for the said Council to represent the same to Her Majesty's most Honorable Privy Council, and the said Privy Council may thereupon issue an Injunction to such Body so acting, directing them to desist from such Practice, and in the event of their not complying therewith, then to order that such Body shall cease to have the Power of conferring any Right to be registered under this Act so long as they shall continue such Practice."

Lord Ebury then hurried off to interview the Home Secretary who had charge of the bill and get his consent to move the adoption of this new clause in the House of Lords. I asked Lord Lyndhurst, whose family physician I was, to support the clause, if needful, in the House. He readily consented, and promised to go there for the purpose, though he was then nearly ninety years old and sadly crippled by chronic gout. The clause was quickly printed and distributed to the Peers. No opposition was encountered, and the bill, as amended, passed the House of Lords without any particular notice. The Lord Chancellor did not even read aloud the new clause, as he said noble lords had it printed in their hands, and the whole business did not occupy five minutes. As a new clause had thus been added to the bill, it had again to pass the ordeal of the House of Commons. This it did a few days later. The reasons for the introduction of the new clause were clearly stated by Mr. Cowper, who was ably supported by some of our staunch friends in the House, particularly Lord Elio (now Earl of Wemyss) and Mr. Brady. The allopaths were taken completely by surprise when they found that a clause for the protection of the homœopaths had been

interpolated into their bill at the eleventh hour. The great obstetrician, Sir J. Y. Simpson, whose venomous hostility to homœopathy was notorious, had apparently constituted himself the accoucheur of the bill, and watched it anxiously through all the stages of its incubation and parturition. He sat by my side in the gallery of the House of Lords when the new clause was added there, but had not the faintest suspicion of what was going on down below him. When he read the Act, after it had passed into law, he must have been dreadfully disgusted that it deprived the licensing bodies of the power to reject candidates for degrees and diplomas on account of their homœopathic proclivities, and no doubt he returned to Edinburgh a sadder if a wiser man, to condole with his fellow-baronet, Sir Robert Christison, the "chucker out" to the faculty of candidates suspected of homœopathic leanings, on the loss of his congenial occupation.

In 1886 the majority of the medical staff of a very old institution, the Infirmary for Consumption, in Margaret street, London, began to feel uneasy because two of their number had become converts to homœopathy, and treated their patients in the infirmary according to that method. This introduction of the accursed thing into an institution which had heretofore enjoyed an unsullied reputation for orthodoxy was intolerable to their colleagues on the staff of the infirmary, who made no concealment of their resolve to get rid of the heretics. I was requested by the intended victims to come and help them. As a preliminary I qualified myself for the post of governor of the infirmary by subscribing to its funds. Several futile attempts were made to induce the two homœopaths to resign. They declined to do so. It was then resolved that they should be expelled. This was a serious step, and had to be done at a general meeting; the governors summoned *ad hoc*. Accordingly, at the beginning of 1887, the eventful meeting was convened. Previous to the date of meeting, the allopathic majority circulated a private letter among the governors, declaring, that if the obnoxious homœopaths were not dismissed they would all resign. They hoped by this threat to intimidate the governors, who might hesitate about depriving their institution of the services of almost all its medical officers. But "the best laid schemes o' mice and men gang aft agley," and the governors no doubt felt that this threat was what is called in pugilistic language "hitting below the belt." The opponents of homœopathy moved "that it having been proved that Drs. Jagielski and Marsh have treated patients of the Infirmary homœopathically . .

· · these gentlemen be requested to resign their positions on the staff of the Infirmary." I proposed, as an amendment, "that any attempt to limit the liberty of opinion or practice of the medical officers is not sanctioned by the laws of the Infirmary, is prejudicial to the interests of the infirmary, and is opposed to the spirit of the Medical Act of 1858." After a long and animated discussion, my amendment was carried by a majority of the votes of the governors, and the allopathic majority of medical officers—seven in number—tendered their resignation on the staff of the infirmary. This did no injury to the infirmary, as their places were soon filled by the election of an equal number of liberal-minded physicians and surgeons, some homœopathic and some allopathic.

Proceedings that resulted from the victory of homœopathy led to the famous discussion on the "*Odium Medicum*," carried on in *The Times* newspaper for about six weeks. It was commenced by Lord Grimthorpe, who occupied the chair at the meeting of the governors of the Infirmary for Consumption. Many well-known members of both schools took part in this controversy, to which I contributed my share. It was generally agreed, even by the allopathic periodicals, that the homœopaths scored most points in the logomachic match. We were so satisfied that all throughout we had the best of the argument that we published and widely distributed the whole of the letters in pamphlet form.

For many years past the medical men of Hahnemann's school had ceased to publish any popular works on homœopathy explaining its doctrines and practice, and it was noticed by many of us that few of the lay public knew what homœopathy was, and were very prone to class it amongst the unscientific quackeries which have always abounded in medicine. We met together to consider how this ignorance could be removed, and the result of our deliberations was that we resolved to form ourselves into a society composed of medical and non-medical adherents of homœopathy for the purpose of diffusing a correct knowledge of homœopathy among the public by means of popular writings and lectures. We called our association the Homœopathic League. We appointed a committee to transact its business, and since 1887 we have published thirty-six popular tracts, forming two volumes. We have reason to believe that these tracts have been very useful in spreading a correct knowledge of homœopathy among the people. Allied associations have been established in France and Spain, and many of the tracts have been translated into Spanish, French, and Italian. Some, I observe, have been

thought worthy of reproduction in American periodicals. The tracts have also been extensively circulated in India and Australia. I took an active part in the league, which has thrown upon me a good deal of not uncongenial work.

I think I have now given you an account of the principal events of my homœopathic history, but perhaps you may not object to hear of some of the other matters more or less connected with medical science which have occupied my attention during my professional career.

In working with the microscope I thought it might be of advantage to be able to examine a considerable quantity of fluid at once. In order to do this I encased the object-piece of the microscope in a metal tube closed at the further end by a disc of thin glass. This glass plate must, of course, be well within the focal distance of the object-glass. In this way an ounce or more of urine contained in a glass cell may be examined at a time. All that is required is to insert the object-piece encased in its water-tight tube into the fluid and work it until the proper focus is obtained. The power I chiefly employ for examination of urine is a one-fourth inch objective and the glass plate at the end of the tube comes to within one-eighth of an inch of the objective. This apparatus can also be used for the examination of the minute organisms contained in other fluids. I described this arrangement of the microscope in the eleventh volume of the *Quarterly Journal of Microscopic Science*.

In 1870-1, while making some investigations into the dioptries of vision, in order to ascertain the precise refractive value of the anterior lens of the eye formed by the aqueous humor bounded by the transparent convex cornea, I extinguished this lens by immersing my eye in water. I then found that perfect vision was restored to the immersed eye by a glass lens which had in air a focal distance of three-eighths of an inch. This lens, in the more refractive medium of water, I found to possess a focal distance of one and one-half inches, consequently this was the focal distance or refractive value of the anterior lens of the eye. It occurred to me that for sub-aqueous purposes it would be better to construct my compensating lens of air. But as the refractive power of air is much less than that of water, my air-lens would need to be concave in place of convex. I found that two watch-glasses having a radius of curvature of one inch placed back to back, that is, with their concave surfaces looking outwards, formed, when immersed in water, a lens whose focal distance is one and one-half inches. This, when placed before

the immersed eye, restored perfect vision. On this principle I constructed a pair of spectacles which, while restoring perfect vision under water, does not interfere with perfect vision in the air. In order to make my air-lens perfect, in place of using watch-glasses, I had the enclosing glasses ground accurately of the exact radius of curvature required. I find these spectacles of great use when diving in clear fresh or salt water, as they enable me to see distinctly all around me. Sir John Herschel, to whom I communicated my invention, wrote me a letter in which he complimented me on its ingenuity. My investigations into the dioptries of vision led me to a new explanation of the mechanism of accommodation, differing entirely from that generally received. I do not think my explanation has been adopted by any prominent authorities on the physiology of the eye except Dr. Jacob, of Dublin, the celebrated oculist, who first described the structure in the eye that goes by the name of "Jacob's membrane." My desire to gain publicity for my view of the mechanism of accommodation led to an animated conflict with the committee of the International Ophthalmic Congress of 1872, in which I gained a signal victory over the anti-homœopathic bigots on the committee who sought to exclude me from the Congress, and prevent me reading a paper on the subject, on the ground that I practised homœopathy. I read my paper, and it is published in the *Transactions* of the Congress. A full account of my views on the mechanism of accommodation and a description of my diving spectacles will be found in a little work I published entitled *The Human Eye; its Optical Construction*.

I have always been very fond of swimming, and have advocated it as a necessary part of the education of all boys and girls. All who dwell on a little island like ours should know how to swim, for if they happened to tumble off and were unable to swim, it might be awkward for them. In 1873 I made a personal inspection of all the swimming-baths of London, and practically tested them all, except two or three, which were so repulsively dirty I could not muster courage to venture into them. I published the results of my observations, first in the *British Journal of Homœopathy* and afterwards in a pamphlet. Since then many more swimming-baths have been established in the metropolis, some of which are superior to any I have described in my article.

In 1879 I got a Poud's sphygmograph, which though in some respects an improvement on Marey's, was yet far from satisfactory. I believed I could contrive a better instrument, so I set to work to

try. A young watchmaker's apprentice from the Black Forest about this time came to London to seek for work. I asked him if he could make a sphygmograph under my direction? He said he thought he could, and after several failures we at last succeeded, and the pocket sphygmograph which bears my name was the result. At first the allopathic authorities, disliking its origin, and yet not liking altogether to condemn what might ultimately prove to be first favorite, hedged cautiously about it, damning it with faint praise, such as "a pretty toy, but not to be compared as to accuracy with the instrument of Marey," and so forth. But now it is generally acknowledged to be the best, and most of the recent writers of text-books on physiology and pathology describe and figure my sphygmograph and no other, and seem quite satisfied that the pulse-tracings it makes are reliable and accurate.

My contributions to homœopathic literature are too numerous to mention, but perhaps my chief claim to remembrance by the homœopathic world is as the translator of all Hahnemann's homœopathic works (except the *Chronic Diseases*) and of many of his pre-homœopathic works. I have been twice chosen President of the British Homœopathic Society, once of the British Homœopathic Congress, and the crowning honor of my life was my selection as President of the International Homœopathic Congress which met this year at Atlantic City. I much regretted my inability to put in a personal appearance on that great occasion, but I am highly sensible of the honor conferred on me by the choice of my American colleagues. I have twice been chosen to deliver the Hahnemann Oration at our hospital here.

I have been engaged in almost every controversy on homœopathy in the medical and lay periodicals. I believe I am the first and only avowed partisan of homœopathy who has defended the method of Hahnemann in the London Medical Society. The occasion was when Dr. Routh read his paper on "The Fallacies of Homœopathy," which he afterwards published in pamphlet form. I was present as a visitor, and after the paper had been read I asked permission to reply. Some opposition was raised to my request, but the president having put it to the vote, the majority decided that I should be heard, and I was listened to with attention, and some of my observations were even slightly applauded. I also took part in a friendly discussion on homœopathy in an allopathic medical society called, if I remember right, the Guild of St. Luke.

I have also taken part in discussions in various periodicals on

Pasteurism, Kochism, vivisection and alcohol-drinking, and I have addressed public meetings on the two latter kindred delusions.

I think the above is about all I can tell you respecting my medical career. I fear your readers will be shocked at the length of my egotistical narration, but please take the blame to yourself. *Tu l'as voulu, Georges Dardin!* You begged me to write my autobiography, forgetting the proverbial garrulity of old age, so you must abide the natural consequences. An excuse must be made for me, viz., that this is my first attempt to write the history of my life. Should Providence endow me with as many lives as a cat (nine, I believe, is the recognized number), and spare me to write a narrative of each, by the time I reached the sixth or eighth I may have acquired the art of writing autobiography with that brevity which is said to be the soul of wit. Naturally the events of our own life are more interesting to ourselves than to others. Even things which at the time were disagreeable and annoying are often not unpleasant in reminiscence, in accordance with the philosophic reflection of pious Æneas: *Hæc olim meminisse juvabit*. They say that wicked French countesses turn devout in their old age for the pleasure it gives them to relate all the pleasant sins of their *beaux jours* in the ear of an indulgent father confessor. So we old men, when we get the chance, love to confide the events of our past life to our patient and much-enduring father confessor "the courteous reader."

At length, however (at what enormous length! your readers will exclaim), I have said all I wish to say respecting my medical career. I will only add, that though in the seventies, I am still hale and hearty. I do my professional work without fatigue, generally manage to play a game of golf once a week, enjoy a week of grouse-shooting over Scotch moors every August, and after that three weeks of the seaside, where, every day after a good long swim in the sea before breakfast, I adjourn to a golf-links and devote all the forenoon to that fascinating game, which I may truthfully say, after the manner of old Verges, "I play as well as any man of my age who does not play better than I." Refreshed by this outing I return to work with renewed vigor, and get through the year with tolerable comfort, the dull routine of practice tempered occasionally by a day off in the country among the partridges and pheasants.

Now you have my whole history, and I hope your readers may be edified and not unduly bored by it. This first experience of autobiography has impressed me with the disadvantages under which an autobiographer labors. In writing the memoirs of others' lives,

the author is free to distribute his praise or blame, as he thinks fit, to his subject's conduct or sentiments, and indeed every competent biographer is expected to do so. But when he writes his own life, he must studiously refrain from auto-laudation. "Self-praise," says the proverb, "is no recommendation." He might, indeed, imitating the self-depreciation of Saint Paul, admit that he had occasionally acted or spoken "as a fool," but few show Dogberry's desire to be "written down an ass," even by themselves. The autobiographer is therefore limited to a bare recital of the acts of his life, and must leave the reader to make his own comments and form his own judgment as to the wisdom or folly of his acts. I trust your readers will be indulgent in their judgment and pronounce a favorable verdict in my case.

I remain yours very cordially,

R. E. DUDGEON, M.D.

53 Montague Square, London, England.

EDITORS OF THE HAHNEMANNIAN MONTHLY:

Gentlemen: The *Transactions* of the Fourth International Homœopathic Congress, and of the Forty-fourth Session of the American Institute of Homœopathy, will be issued about the 1st of February, in a single volume of about 1150 pages, octavo, and handsomely bound in cloth, similar in style to recent publications of the Institute. The delay in issuing the work was due to the unusual amount of editorial and mechanical labor involved. Copies will be promptly mailed to all members of the Institute not in arrears, and to all foreign homœopathic physicians who contributed, in any way, to the success of the Congress; besides which, the usual copies will be sent to homœopathic colleges and journals, and to the public libraries designated by the Institute. It is requested that any homœopathic journal in the world, failing to receive a copy, will notify the undersigned.

After retaining sufficient to supply the Institute membership, etc., there will be some twenty-five or fifty copies left over. These, the Executive Committee will offer for sale at seven dollars each. Purchasers will please remit the amount to the Treasurer, Dr. Thomas Franklin Smith, 264 Lenox Ave., New York city, and the book will be forwarded by mail.

PEMBERTON DUDLEY, M.D.,

General Secretary, A. I. H.

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EDITORIAL.

THE REMOTE EFFECTS OF THE REMOVAL OF THE UTERINE APPENDAGES.

IF we are to judge from communications that have appeared in various medical journals within the past two months, a very healthy skepticism concerning the beneficial effects to be derived from the castration of women has arisen. In our December issue, we took exceptions to the laparotomy craze that has pervaded the land for the past few years. Since then we have had the pleasure of reading several papers tending to shed light on this all-important subject.

The first of these, from the pen of Dr. Thad. A. Reamy, of Cincinnati, appeared in abstract in the November issue of the *American Journal of Gynecology*. This paper gave the ultimate results of cases operated upon by the author from 1884 to 1889 inclusive. Accurate histories were obtained of 166 of his patients, for periods of from two to five years subsequent to the operation. The following were the results: Positive cures, 42; much improved as to local disease and general health, but not cured, 70; temporarily improved but after a period of one to three years relapsing into conditions as bad or worse than when operated on, 36; in no way improved, 18. In every case in which the ovarian structure was entirely removed, menstruation ceased, either at once or within a few months. Data as to the sexual appetite of patients were obtained in 44 cases; in 14, sexual appetite was totally extinguished; in 7, lessened, but not extinguished; in 16, not influenced; in 7, markedly increased. Of course, figures stated in a general way, as the above are more suggestive than conclusive, for there is not given (at least in the abstract) the character of cases in which success and failure respectively occurred. For information on this point we are obliged to rely upon the author's general statement of his own conclusions which are as follows:

1. Pyosalpinx does not exist in nearly so large a proportion of cases of pelvic diseases, encountered in patients from the middle and upper classes as is generally claimed by authors.

2. In these classes gonorrhœa does not play nearly so important a rôle in causation as is generally believed.

3. In properly-selected cases, removal of the uterine appendages promises most satisfactory results, and should be promptly done.

4. Removal of the appendages for the cure of hystero-epilepsy, has been too severely condemned of late. In certain cases the procedure offers much hope.

5. The measure is not warranted by sound reasons, nor by clinical experience, for the cure of purely neurotic cases.

6. Many cases of pelvic disease, involving the appendages and cured by their removal, could be as thoroughly cured by more conservative methods, which do not sacrifice those important structures.

7. Many cases, promptly reported to societies and in medical journals as cures, if carefully watched for a few years, will be found to be in no better condition than when operated on. Their publication has been misleading.

. . . . 11. The relation of the conditions established by the removal of these organs to the psychoses is not, perhaps, fully appreciated.

In other words, the author is a strong advocate for operative measures in cases of structural disease of the appendages, as pyosalpinx, incurable ovaritis, etc., but looks upon oöphorectomy as useless in purely neurotic cases, and a procedure of considerable promise in hystero-epilepsy. This, of course, brings up the question as to what constitutes a hystero-epilepsy curable by laparotomy. We think that altogether too many troubles in women are attributed to uterine disease. For example, we have recently been made acquainted with an undoubted case of syphilitic locomotor ataxia in a woman, with uterine fibroid, in which a gynæcologist of eminence had promised a cure of the spinal trouble, when the fibroid should be cured.

Returning to the subject of recent papers on the remote effects of removal of the uterine appendages, we find also in the *American Gynecological Journal* an abstract of a paper by Dr. E. W. Jenks, of Detroit, the general schema of which is a severe criticism of the operative treatment of ovarian diseases, and a most earnest plea for the general adoption of more conservative treatment than seems at the present day to be popular.

The most searching review of our subject, however, is to be found in the *University Medical Magazine* for December, and is from the pen of Dr. Wharton Sinkler, of Philadelphia. As was to be expected, the subject is considered from the standpoint of the neurologist. The author says:

"Operators as a rule know but little of the condition of their patients after they have recovered from the immediate effects of the operation. They pass out of their hands and return to the care of

the family physicians, or if not relieved of the trouble for which they sought an operation, go to another gynæcologist, or to the neurologist."

Dr. Sinkler says very properly that two questions must be borne in mind in considering the ultimate results of the removal of the uterine appendages: First, if the operation was resorted to for disease of the ovaries; or secondly, if the operation was done for the relief of nervous troubles aggravated at the menstrual period. He then proceeds to state that he has seen many most excellent results to follow the removal of the appendages for the relief of pyosalpinx, ovaritis, and other inflammatory diseases of these organs, the general testimony being to the effect that the results in these cases are permanent. The author then proceeds to state the general conclusions that he has reached from the study of the experience of himself, and a large number of professional friends. The physiological effects of the operations are in most cases those incident to change of life, and that too, whether the removed organs be diseased or not. The climacteric phenomena are especially severe in young subjects. If the operation is performed shortly before, or shortly after puberty, the development of sexual characteristics is arrested; but if not until after the patient has reached full womanhood, no change in feminine characteristics takes place. The general idea that women upon whom the operation has been performed become coarse and masculine in appearance, is entirely erroneous.

Dr. Sinkler proves by quotations from his own experience, as well as from the observations of others, that numerous cases of mental disturbance find their origin in removal of the uterine appendages. In most instances in which unfortunate results occur, the patient is simply restless and depressed mentally. In other cases, the trouble increases to a mild melancholia. Occasionally, mania follows closely on the operation, or a mild form of insanity develops, and becomes a chronic mania. It is claimed by some surgeons that insanity follows so closely on operation in some cases, as to hardly leave the relation of cause and effect to be a matter of doubt. Women especially are liable to this unfortunate result, because of their more emotional nature. While acknowledging this, we truly believe that more cases follow operations on the female genitals than elsewhere. There is a reason for this. The tendency to nervous disturbances at the climacteric is universally recognized. If then the physiological effects of the removal of the uterine appendages, are the phenomena incident to change of life, we have every reason to fear the complica-

tions that may occur at that epoch. Tait, however, in his enormous experience, claims to have met with no cases of post-operation insanity. We cannot believe him to be a reliable authority on this point, for with the immense amount of time he must take up in operating and examining his cases, he can have but little remaining to follow up the subsequent results. Dr. Sinkler himself states that he has had under treatment several cases of insanity that developed several months after removal of the ovaries. He is thoroughly impressed with the idea that a large number of cases in which some form of mental disease does occur after these operations will be found on investigation.

“As to the benefit derived by patients who have undergone oöphorectomy for insanity, epilepsy, hysteria, and the different forms of neuralgia and nerve troubles, Dr. Sinkler says: ‘The opinions of different observers vary to such an extent that we might believe that totally different beings and conditions were considered. Certain writers give the most glowing accounts of the benefits obtained by almost every patient operated upon, while others regard the results as being always so unfavorable, that the operation is never justifiable.’ For instance, Dr. Ross, of Toronto, says: ‘that the removal of the uterine appendages is never a legitimate procedure in a case of purely functional neurosis, and that even when marked structural disease of the appendages coexists with severe neurotic conditions, the latter should be treated in the first instance in the hope that the operation might be avoided.’

“As is generally the case the truth lies between these two extremes. There are certainly a large number of cases of hysteria, neurasthenia, and allied conditions depending upon diseased ovaries which do not get well under the most judiciously applied treatment, and who do make a good recovery after removal of the offending organs. In cases of extreme dysmenorrhœa, this is conspicuously true. A patient suffering from the severer forms of pains at the menstrual period barely recovers from one period before another comes. On the other hand, a vast number of patients have had their ovaries removed for hysteria, insanity, and the like, who are temporarily relieved by the operation, but in a few months are in as bad a condition as ever, and who recover permanently after a course of systematic treatment directed to the nervous system.”

Weir-Mitchell, Playfair, Spencer Wells, Skene, Brodwitz are quoted to the effect that many neurotic cases are much worse after the operation than they were before. We have recently, that is since writing the December editorial, come across two cases of this nature. The first had been operated upon by a rising young laparotomist, who has not hesitated to brand his professional associates as dis-

honest, and homœopathsists as quacks. To use this patient's own words, she had been far worse since the operation than before. The other was a case of pyosalpinx in which the local suffering had been replaced by neurotic symptoms, as dyspepsia, neuralgia, etc., and which were considered as even more severe than the original complaint. Of course, in this latter case, the operation was the only measure possible; yet the result was unfortunate.

Our author says that the immediate effect of the operation in neurotic cases is relief. This he believes would follow almost any operation.

Even when the operation has been done for the relief of pelvic pain it does not invariably accomplish its object, especially when the pain is neurasthenic and not associated with disease of the ovaries. Among Dr. Sinkler's conclusions we find the following:

"The remote effects of removal of the ovaries and tubes upon the general health are, as a rule to improve nutrition and to better the strength, especially if the operation has been done for diseased ovaries and pus tubes.

"That it is often the case that after this operation patients are more nervous than formerly, and mental disturbances of various forms, insanity and epilepsy, not infrequently follow it.

"That the influence of the operation is sometimes good upon insanity and epilepsy which are associated with severe dysmenorrhœa or occur periodically at the menstrual periods; but when the insanity is constant, although it may be aggravated at the monthly periods, removal of the ovaries is of no benefit. Hystero-epilepsy is seldom permanently cured by this operation. Prolonged after treatment is generally necessary to relieve such cases.

"Certain cases of neurasthenia which are associated with dysmenorrhœa, or with structural changes of the ovaries, are cured by the operation; nevertheless, no such case should be subjected to the operation without beforehand having the benefit of prolonged and patient treatment. It is unjustifiable to remove the ovaries and tubes in cases of hysteria, neurasthenia, etc., when these organs are healthy."

In the *American Journal of Obstetrics* for November is a paper by Dr. Wm. T. Lusk, a well-known obstetrician and gynecologist of New York, bearing the title of this article. The general tenor of the communication is a protest against indiscriminate oöphorectomies as useless if not absolutely harmful, and making the claim that many apparently hopeless cases are amenable to non-operative treatment. The author relates the following extreme case:

"The patient when I first saw her some years ago, was a young woman of seventeen. She had suffered agonizing pains at monthly

intervals, and was confined to her bed or couch the greater part of the time. An examination revealed occlusion of the lower part of the vagina. An opening was made, and a large amount of retained blood and clots was removed from the upper vagina and uterus. The latter had been converted into a sac. For a long time thereafter the tubes had remained thickened and tender. This was especially marked on the left side, to which the fundus was drawn by peritoneal adhesions. Salpingotomy was plainly indicated, and I should have performed that operation had I obtained the patient's consent. Finally, however, she married. My advice in the matter was not asked. Last June the young woman came to me. She had been married a year and was seven months pregnant. The thing was inconceivable but it was a fact."

Dr. Lusk acknowledges having had insanity follow some of his operations, and admits failures to cure in others. He furthermore makes the claim that the majority of his cases of tubal and ovarian swellings yield to well-directed local and constitutional measures. He says that in large and tender tubes he resorts to rest, the vaginal tampon, douches, massage, faradism and a tonic regimen. If the tubal swelling is intermittent, and is associated with a narrow cervical canal, he is not afraid to use Goodell's dilator to secure free drainage of the uterine cavity.

Dr. Lusk's paper called forth a paper from Dr. Charles Carroll Lee, also of New York. (*University Medical Magazine*, December, 1891.) Dr. Lee agrees with the other essayists in the main, but acknowledges that he discriminates most carefully as to the cases he operates. He gives the ultimate results of no less than 26 cases whose histories he has followed for periods of five years or over. It must be confessed that these make a tolerably good showing. In his general conclusions he states that the relief of local pain was most generally unsatisfactory for the first year. Certain secondary local effects of the operation interfered very much with the patient's health. The remote effects on the nervous system and the general health were in the main most excellent. In no single case in which the patient was purely neurotic did the patient become securely well; but he did not find any mental depression or derangement follow in any case.

The papers from which we have quoted so largely furnish very interesting reading. They can hardly be said to be conclusive, instructive though they be. The need of the hour is complete reports from all operators, and not the continued quotation of Mr. Tait's "say so" that oöphorectomy is not done as often as it should be, and that no harm has resulted in his cases.

THE WASHINGTON MEETING OF THE AMERICAN INSTITUTE OF
HOMŒOPATHY.

"GRIPPE"-stricken Washington is slowly recovering, and while nothing is definitely settled, the flag signals indicate that the American Institute of Homœopathy will hold its forty-fifth session and celebrate its forty-ninth anniversary at Washington, D.C., beginning on Monday evening, June 13th, at 7.30 o'clock, and continuing until Friday P.M., June 17th, or until its business is transacted. The probable place of meeting will be the "G. A. R." Hall, Pennsylvania Avenue, opposite Willard's Hotel. Headquarters for members will be the Ebbitt House, and for overflow, Willard's and the Riggs House. The Bureau of Registration for the Local Committee, and the permanent headquarters of this committee will be at Willard's Hotel.

The opening-night will be devoted to the President's Address, and a reception tendered to the members of the Institute and their friends by the physicians and laymen of Washington. It will be held in some large hall or theatre; the place has not yet been selected. Addresses of welcome will be made by prominent citizens, and the audience will be entertained by the Marine Band of Washington. Later in the week it is proposed to take a trip to Mount Vernon, and there will probably be held a symposium at the classic and historic "Marshall Hall" on the Potomac opposite Mount Vernon, the idea being to do away with the time-honored but tiresome, formal banquet. The committee is to be congratulated for taking this stand, and it is to be hoped that they will adhere to their present intention.

These arrangements all indicate that the Local Committee is alive to its responsibilities. And now, reader, what have you done, or what are you doing, to assist in making the coming Washington meeting the most successful in the history of the American Institute? What thought and preparation have you given to that paper you are going to present and read at the next Institute meeting? If you have not commenced, it is about time that you did. How many members of the profession have you spoken to or written to, asking and urging them to interest themselves in and join the Institute, and do something for the general good of homœopathy? If not one, it is time now for you to commence.

PROFESSIONAL INHUMANITY.

A FEW months ago the daily press, all over the country, were heaping censure upon the inhuman conduct of a physician in Maryland, who, after sewing up a wound, cut the stitches he himself had inserted, because the patient announced his inability to pay for the services. Scarcely less inhuman is the custom among some allopaths, happily a very small minority, of refusing positively to give aid to the sufferings of those who are accustomed to employing homœopathsists as family physicians. This matter has been brought very forcibly to our attention by a recent incident. Until it occurred, we had believed such a thing impossible in the present stage of the nineteenth century civilization.

A dental surgeon was administering ether to a patient, when serious symptoms suddenly developed. Finding that he needed advice and help, he sent a cab with a competent messenger to the nearest physician on whom he could rely, and who happened to be a homœopathist. The latter, however, was not at home. The messenger, knowing the necessity of having some one at once, then called upon a physician next door, and asked him to come at once. He refused, saying that Dr. — was a homœopath, and he would not have anything to do with either him or his patients.

The most charitable view to take of this inhuman action is, that the allopathic doctor did not know what to do to aid the patient; seeking an excuse for non-attendance, he chose to acknowledge himself a knave rather than a fool.

ON January 13th, 1892, Director Beitler, of the Department of Public Safety, Philadelphia, in accordance with the direction of City Councils that the city should have the benefit of five Medical Inspectors, immediately appointed five *allopathic* physicians to fill the places, continuing the systematic ignoring of homœopathic physicians and of the homœopathic voters of Philadelphia, who pay nearly one-half of the city taxes. The question naturally arises, how many of the four hundred homœopathic physicians of the city of Philadelphia have entered a protest against this unjust discrimination of Director Beitler? No representation in the Philadelphia City Hospital! No representation in charge of an Insane Asylum! No representation in a single official appointment in Philadelphia! With the mighty power and influence that four hundred united and deter-

mined homœopathic physicians and their friends can wield—waiting to be used! How long are homœopathic physicians going to sleep and submit to this intolerant imposition? The plea of being too busy with private practice is not admissible.

ON page 25 of the *News and Advertiser* will be found the "General Statistics of the Five Massachusetts Hospitals for the Insane for the year ending September 30, 1891." The statistics are tabulated, and show at a glance the vast superiority of the results obtained at the Homœopathic Asylum for the Insane at Westborough, in charge of Dr. N. E. Paine. The table is worthy of a careful investigation, and should be used in States having no insane asylum under homœopathic care, to assist in securing the establishment of asylums where insane patients can receive the benefit of scientific treatment.

ERRATA.

DR. E. FORNIAS desires that the following corrections be made in his paper on "Pyretology," appearing in the number for January, 1892:

On page 39, under Collapse Temperature, read "moderate" for "modern."

On page 41, in the Gradual Ascent of the Temperature in Typhoid, change "103.3° F." and "103.56°" to "101.3° F.," and "102.56° F."

On page 49, fourth line, insert dash between animal and sensation, and change dash to comma after sensation, to read as follows: "The functions of relation or animal—sensation, muscular motion, mental manifestation—are those," etc.

JOHN W. DOWLING, M.D.

PROF. JOHN WILLIAM DOWLING, died on Thursday night, January 14, 1892, of paralysis of the lungs and heart, in Dr. Seward's sanitarium, at Goshen, N. Y. Dr. Dowling was born in New York city, August 11, 1837, and when twenty years old graduated from the Hahnemann Medical College, in Philadelphia, in the class of 1857. He at once commenced practice in partnership with Dr.

S. S. Lungren, of Hagerstown, Md., remaining one year; he then became associated in practice in New York city with Dr. Abram D. Wilson, one of the pioneers of homœopathy. In 1870 Dr. Dowling accepted the chair of Theory and Practice in the New York Homœopathic Medical College, and in 1872 became dean, a position he held until 1884. It was due to his efforts that a hospital was established in connection with the college. Dr. Dowling retained his professorship of Physical Diagnosis and Clinical Medicine in the college until his health failed, and he was obliged to give up practice. He was a member of the Union League Club, an ex-president of the American Institute of Homœopathy, an ex-president of the Alumni Association of "Old Hahnemann," Philadelphia, and an honorary member of the Homœopathic Medical Society of the State of Pennsylvania, a member of the New York State Homœopathic Medical Society, and consulting physician to the Hahnemann, Ward's Island, and Flower Hospitals. Dr. Dowling leaves a widow and three children, one daughter, and two sons, Dr. J. W. Dowling, Jr., of New York city, and Dr. George B. Dowling, of South Orange, N. J.

HARRY BROOKS TINDALL, M.D.

On the morning of January 16, 1892, Harry Brooks Tindall, of Philadelphia, died of typhoid fever, in his 25th year. Dr. Tindall was a graduate of the Hahnemann Medical College of Philadelphia, graduating with honor in the class of 1890. He immediately entered the Pittsburgh Homœopathic Hospital, in which institution he served with credit to himself and the profession until October, 1891. He then returned to Philadelphia, and was associated in practice with his father, Dr. Van R. Tindall. He was rapidly forging to the front as a skilful surgeon and successful practitioner, when death stepped in and cut short what promised to be a brilliant career.

ARCHIBALD BAYNE, M.D.

DR. ARCHIBALD BAYNE, a native of Barbadoes, West Indies, and a graduate of Hahnemann Medical College of Philadelphia, in 1879, died at his home on November 19, 1891, of Bright's disease. The doctor enjoyed a large and lucrative practice, and was a prominent liberal member of the House of Assembly.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D.,

FRANK H. PRITCHARD, M.D., AND EDWARD M. GRAMM, M.D.

ACUTE ULCERATIVE ENDOCARDITIS.—Dr. Byres Moir, in the *London Homœopathic Hospital Reports*, 1891, reviews the subject of acute ulcerative endocarditis and gives in detail the history of five cases treated at the hospital. He adopts Woodhead's distinction from simple endocarditis: 1. Local action more destructive. 2. Fragments detached and carried into the circulation give rise to more rapid and widespread mischief than do emboli from the simple form. 3. The naked eye vegetations tend to occur more indiscriminately over the endocardial surfaces of the valves or the heart walls, and they tend more readily to break down and leave ulcerated patches. Dr. Moir classifies the cases reviewed and reported as follows: 1. Those in which the cardiac disease is only part of a general pyæmic process and in which the emboli give rise to secondary abscesses. 2. Those in which the cardiac disease is a primary affection, or follows after old valve lesions, and the emboli give rise to simple infarcts. Then follows the complete history of five cases, all fairly typical, presenting fever of a pyæmic character, rapid pulse, enlargement of the spleen, vegetations of the endocardium with ulceration, and infarcts in various organs. They all terminated fatally, the post-mortem examinations being given in full. They all came under the class known as "cardiac cases," none being part of a general pyæmia. Four out of five had previous valvular lesions, and in only one could it be looked upon as a primary disease. Two cases had a distinct history of acute rheumatism; in one there was a clear account of rheumatism, though not of an acute attack. In three, anæmia was a very marked feature when they came under observation. Dr. Moir considers anæmia to be one of the factors producing ulcerative endocarditis, especially when there are already present valve changes. The doctor agrees with Dr. Goodhart's opinion that in anæmia high tension of the pulse and the dilative changes in the left ventricle causes undue tension on the valves, and strongly advises active and early treatment of the anæmia. Two of the cases strongly emphasized this condition; they were both children of the poorer class, who, when they came under notice, were very anæmic and suffering from valve lesions, and no other cause than the debilitated condition could be assigned as the starting point of the inflammatory process. Another, a man of fifty-seven years, was in a very weak and anæmic condition, and suffering from cirrhosis of the liver at the time of the cardiac attack. With regard to the theory of micrococci infection he holds with Dr. Bramwell, "that although micrococci may be present in simple endocarditis, it is only in weak and debilitated states that these little bodies thrive." One of the cases occurred in a young man of twenty-one, of previous good health and without history of syphilis, being a primary case without assignable cause. Only slight ulceration was found on the aortic valves, and the whole severity of the disease fell upon the root of the aorta, and in reality was a case of acute ulcerative endocarditis, in which an aneurism had formed from perforation of the inner coat. Dr. Osler has reported a somewhat similar case in a man of thirty, who had suffered from syphilis and also aortic incompetency.

In the case of a girl, aged thirteen, who came under Dr. Moir's treatment for severe heart trouble, the temperature for sixteen days varied from normal to 104.2°, after that it was subnormal, and the case was not seen from August 31st till December 17, 1890, and she then sank from heart failure. Dr. Osler claims to have met cases where the febrile symptoms have subsided for weeks, to recur again with increased severity, and he states that there are cases which render it probable that the process may subside entirely.

Under treatment the doctor had found medicines to be without influence until the last case came under his care. Dr. Hughes suggested the use of aconite (based on

Jousset's statement that aconite will produce endocardial inflammation in rabbits), mother tincture (not that of the root), two drops every two or three hours, if necessary, to be followed up with chininum arsenicosum in grain doses of the first trituration. In the child of thirteen years this was tried with marked benefit, the child leaving the hospital much benefited. The case was readmitted some four months afterward in a dying condition from heart failure, and at the post-mortem a cicatrix was found on the wall of the left auricle, which was, in all probability, in the ulcerative stage during the acute attack. Two drops of aconite, mother tincture, every three hours, was given to the patient with a feeble pulse with reluctance, but instead of lowering the pulse it had the opposite or tonic effect.

In the *Lancet* of June 20, 1891, a case of recovery is reported at St. Bartholomew's Hospital. The symptoms were typical of the disease; rigors were frequent and severe, the temperature several times reaching over 106°. Valvular disease was present, the bruit varying from time to time. The chief point of interest lies in the treatment, for, besides aperients and sedatives, quinine, aconite and perchloride of mercury were given. Treatment was not considered to have had any effect, but the history of the case shows that the greatest improvement took place while the aconite was being administered. One minim of the tincture was given every six hours for eleven days, and during this time the temperature was materially lower, becoming normal, and the rigors were less frequent. This case left the hospital with one symptom remaining—a loud systolic murmur at the lower end of the sternum. Dr. Moir considers that we may look to aconite as the remedy most likely to be of service in acute ulcerative endocarditis.

TREATMENT OF MEDICAL HÆMORRHAGE.—After showing the means in general use for the stoppage of hæmorrhage in internal organs are almost useless, if not harmful, Dr. Dawbarn presents the plan on which he has relied, and from which he believes he has obtained good results. This plan is to simply collect a great portion of blood elsewhere than at the bleeding point until time has been given for a firm clot to form—say an hour or so—and then slowly allow it to re-enter the general circulation. It is plain that this sequestration, especially if carried to the point of causing a feeling of faintness, must diminish the blood-pressure at the bleeding point and thus conduce the clotting. The Spanish windlass is to be used. That is, a towel or handkerchief is to be knotted loosely around one limb (or, if need be, the same method on all four limbs at the junction with the body), and by twisting this with a stick blood is prevented returning to the trunk. In consequence the limb swells visibly. The arterial circulation is not shut off. The limbs should be watched and kept well warmed. The constriction should not be maintained too long, lest gangrene result. This treatment Dr. Dawbarn advises in the earliest stages of apoplectic attacks, and for the cure of pulmonary hæmorrhages.—*Medical Record*, January 2, 1892.

A NEW METHOD OF TRANSFUSION.—Dr. Dawbarn shows that a saline solution is the only fluid required in the operation of transfusion for exhausting hæmorrhage. The strength employed is that of a heaped teaspoonful of salt to a quart of water as warm as can be borne by the hand. The water should first be boiled for aseptic reasons. The instruments required for the operation, are an ordinary Davidson's syringe; an ordinary soft rubber catheter or a small rubber drainage-tube; and an ordinary hypodermic needle, large size preferred, though this is not essential.

Even if our patient is pulseless at the wrist, we can almost to a certainty feel the femoral beating just below Poupart's ligament. Now take the needle—not as yet attached to the catheter—and push it directly into this artery; going slowly, until bright-red blood is seen to well up from within the needle. (As the artery here is large enough to carry a lead-pencil, the needle will not easily miss it, with a little care.)

As soon as the arterial blood is seen in the needle, slip over its base the catheter—already attached to the syringe, the nozzle of which has entered it at the eye, and both being filled with the warm salt-water—and tie a thread tightly about the catheter, securing it to the base of the needle.

Now holding the needle in place firmly and steadily, pump the fluid directly into the arterial current. To avoid possible pumping of air by an old or leaky syringe, make an abundance of the salt-water, and keep the entire syringe, with the hand working it, beneath the surface.—*Medical Record*, January 2, 1892.

CONVULSIONS TREATED BY COMPRESSION OF THE CAROTID.—Dr. Leopold Roheim, of Budapest, publishes in the *Gyogyaszat* a case of eclampsia which he had, after the failure of all other remedies, successfully treated by compression of the carotid. The case was that of a robust man of fifty-six, who had been suffering for a number of years from cancer of the bladder with occasional hæmaturia. The man had been attacked with a most violent eclamptic paroxysm, which was mainly confined to the left side. Roheim prescribed in vain, musk, valerianate of zinc, assafetida, hypodermic injections of morphia, enemata of hydrate of chloral, and frictions with mustard, and at last employed compression of the carotid. After compression for some time of the right carotid, the convulsions were suddenly arrested, the patient recovered normal respiration, and very soon felt quite well. Two or three slighter attacks followed, which were soon arrested by properly instructed attendants. Roheim compressed the carotid with the index and second finger between the larynx and sterno-cleido muscle back towards the spine. He considers the rationale of the treatment to be that by compressing the carotid and at the same time necessarily the sympathetic nerve fibres, which closely follow the course of the artery, the excitability of the brain is allayed.—*The Lancet*, January 2, 1892.

TREATMENT OF RATTLESNAKE BITE.—Dr. A. W. Barber formulates the treatment for poison of the rattlesnake as follows: 1. Free incision to the bottom of the wound and immediate cauterization; or, if this is not practicable, sucking of the wound. 2. The immediate application of an intermittent tourniquet,—that is one which is relaxed for a moment at a time—so that the poison may gain admission into the system in small doses. 3. The free administration of alcohol or carbonate of ammonium. 4. Free incisions into all portions of the inflamed tissues, and the thorough kneading into these incisions of a fifteen per cent. solution of permanganate of potassium. 5. Multiple injections of the same solution into all the inflamed regions, but particularly in the region of the wound. 6. The complete surrounding of all the involved tissues, by permanganate of potassium injections placed from half an inch to an inch apart, the needle being driven into the healthy tissue just beyond the line of demarcation, and its point being carried to the deepest part of the border of the indurated area. 7. The permanganate of potassium solution should be used freely in fifteen per cent. solution. The author has used one and a half drachms of the drug diluted, and he would not hesitate to use four times that quantity were it necessary, since it seems to exert no deleterious effect, either locally or generally. 8. The involved area should be dressed by means of lint saturated with fifteen per cent. permanganate of potassium solution. Stimulants should be given according to the indications, i.e., the condition of the pulse. Laxatives, diuretics, and diaphoretics should be administered to aid the elimination of the poison. The diet should be as nutritious as the stomach can digest.—*Therapeutic Gazette*, January 15, 1892.

THE USE OF TEUCRIUM SCORDIUM IN PRURITUS ANI.—The use of this remedy in pruritus ani was first recommended by Dr. Andre Lebel, of Paris, some twenty-five years ago, in the following words: "The cure is perfect. Do you doubt? Try it. Three or four days at most, of treatment, will assure you as to its value. This treatment is simple, natural, harmless. Try it. You risk at most only the loss of three or four days." It was these words that induced Dr. J. H. Brinton to try the remedy. The results he has found to be fairly satisfactory. Great relief is obtained in from a week to ten days. It is especially valuable in the treatment of early hæmorrhoids, accompanied by pruritus occurring especially in young persons. In more advanced cases after the tumors have been fairly developed, it does not exert much influence. Its soothing and curative effect seems to be confined to the initial period of the disease, and to the disturbed neurotic condition. The dose is ten or twelve grains of the powder suspended in water, taken three times a day, about half an hour before meals.—*Therapeutic Gazette*, January 15, 1892.

PEMPHIGUS OF THE MUCOUS MEMBRANE OF THE MOUTH, PHARYNX AND LARYNX.—Mandelstamm observed five cases of a peculiar affection of the mucous membrane. There appeared in all of the cases diphtheria-like epithelial alterations upon the mucous membrane of the mouth, pharynx and larynx (all in Hebrews). These lesions often covered a large area of the mucous membrane, and were from the size of a pea to that of the palm of the hand, which either disappeared rapidly without the production of a scar, or else coalesced and remained a

long time. They never separated in their whole extent, but cracked in numerous places, showing the mucous membrane beneath. No fever was present. Remedies seemed of no avail, so that four of the patients stopped treatment after the lapse of a few weeks; the fifth one remained under observation for a longer time and reported one day with a universal pemphigus foliaceus. As no blebs were to be found upon the mucous membrane, the author surmises that the irritation was insufficient to produce a vesicular elevation of the epidermis of the mucous membrane. He calls his cases primary pemphigus of the mucous membrane.—*Monatsh. für Prakt. Dermatologie*, Bd. 13, No. 8, 1891.

BLOOD CHANGES IN CONSEQUENCE OF SYPHILIS AND AFTER THE USE OF MERCURY.—W. Biganski examined the blood of thirty fresh cases of syphilis before mercury had been administered and found:

1. That the number of the red blood corpuscles was unchanged.
2. That the white corpuscles were markedly increased in numbers; about twice as many being present. The small lymphocytes with one nucleus among the white corpuscles averaged about 35 per cent., instead of being from 15 to 20 per cent. of the total.
3. There was a constant diminution in the amount of haemoglobin; in men it averaged about 90 per cent and in women about 70.8 per cent., instead of 90 per cent.

Mercury was administered to seventeen of the patients in the form of inunctions of three grammes at a dose, six received calomel injections and seven were given the yellow iodide of mercury by the mouth. The blood was examined once in from five to seven days, with the following results:

1. The number of the red blood corpuscles underwent great variations.
2. The white corpuscles decreased about 30 per cent.; the ratio of the lymphocytes to the multinucleated corpuscles returned to the normal condition.
3. The amount of haemoglobin showed a constant increase of from 10 to 18 per cent.—*Monatsh. für Prakt. Dermatologie*, Bd. 13, No. 8, 1891.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

PARENCHYMATOUS AND INTRA-ARTICULAR INJECTIONS IN THE TREATMENT OF TUBERCULOSIS OF BONES AND JOINTS.—Senn, after reviewing the literature of this subject and reporting several cases, draws the following conclusions:

1. Such injections, with safe anti-bacillary substances, are indicated in accessible, subcutaneous, tubercular lesions of bones and joints.
2. Iodoform has yielded the best results in this method of treatment. Balsam of Peru ranks next and, if iodoform has failed, or, for any reason, cannot be employed, it should be given a trial.
3. Iodoform owes its curative effect to its anti-bacillary action, as well as to its stimulating effect on the healthy tissues about the tubercular foci.
4. Iodoform is best administered subcutaneously as a ten per cent. emulsion in glycerine or pure olive oil. Not more than half a drachm of iodoform should be used the first time, but the quantity may be increased in the absence of systemic symptoms. Ethereal solutions should never be employed, as necrosis of over-lying tissues and intoxication are likely to result.
5. Abscesses and joints containing synovial fluid or pus should be washed out thoroughly with a three to five per cent. solution of boric acid before the injection is made.
6. Injections should be made every one or two weeks and repeated until the tubercular process ceases and repair is substituted, or until the treatment shows its inefficacy, or indications calling for operative measures present themselves. As a rule symptoms of improvement manifest themselves after the second or third injection; these are, a gradual diminution in the contents of the joint or abscess at each successive tapping, lessening of the solid contents of the fluid, and an increase in its viscosity.
7. The limb can be used in moderation during this treatment provided existing

deformities do not contraindicate such use. The correction of deformities should be postponed until the primary joint affection has been cured by the injections.

8. This method has yielded the best results in tubercular spondylitis attended by abscess formation and in tuberculosis of the wrist and knee.

9. In joint involvement following primary osseous tuberculosis this treatment will be successful provided the osseous foci are small. If, however, this secondary synovitis is consecutive to extensive sequestration of the articular ends, resection is always called for, but preliminary treatment by iodoform injections into the affected joint is valuable and will aid a favorable result.

10. When a radical operation can be avoided in open, tubercular joint affections the method suggested by Billroth should be employed, one which has given very favorable results, *i.e.*, incision, scraping, disinfection, iodoformization, iodoform gauze tamponade, suture and subsequent injections of iodoform emulsions.—*Annals of Surgery*

OBSERVATIONS UPON THE ANATOMY AND SURGERY OF THE URETER.—Cabot has made a series of dissections with a view of determining the surgical accessibility of the ureter in the different parts of its course. When possible it is always preferable to use an extra-peritoneal incision for the removal of a stone, the ureter being so thin-walled that its closure by sutures must necessarily be hazardous. The anatomical description of the course of the ureter is of but little assistance in a surgical search for the lax, collapsed tube deep in the tissues. By microscopic examination the writer found that the ureter was firmly bound to the under surface of the peritonæum by fibrous bands which accounts for the fact that it separates with the peritonæum as the latter is stripped up from the parts behind. Furthermore the ureter lies very close to the point of adhesion of the peritonæum to the spinal column. If then during an operation the peritonæum is stripped up to its attachment to the spine, the ureter will be found upon the peritonæum at a short distance outside this point. On the left side this will be about one-half inch, on the right more, because the ureter is displaced by the vena cava to which it is in close apposition.

To reach the ureter in the abdominal part of its course, and in the upper part of the pelvis, the incision is best made at a point varying with the location of the stone, in the posterior, middle, or anterior portions of the line suggested by Israel. This is drawn from the anterior edge of the sacro-lumbar mass of muscles, a finger's breadth below the twelfth rib, parallel to the rib as far as its tip; then downward toward the middle of Poupart's ligament to the line of incision usually used for tying the iliac artery; finally inward, toward the middle line, to the external border of the rectus muscle. After the ureter dips into the pelvis it is less easily located as it bears no relation to the bony landmarks, but fortunately a hard body, the calculus can usually be felt. Practically however the lower three or four inches of the ureter cannot be reached from in front by an extra-peritoneal incision, but it is just here that stones are most likely to lodge and particularly just at the vesical opening where the tube narrows. If the calculus projects into the bladder or lies in that portion of the ureter between its muscular and mucous coats the method of choice would be to remove it by the suprapubic route; but if an incision of the bladder wall is necessary to uncover it, urinary infiltration is to be feared. In order to reach the ureter in these last three or four inches from below the writer proposes a modification of the Kraske incision based upon dissections and cadaver operations. An incision is made along the border of the sacrum, on the side upon which the ureter is to be reached, to just below the tip of the coccyx, the sacro-iliac ligaments are divided, the coccyx and the lower part of one side of the sacrum removed; ready access to the lower three or four inches of the ureter is obtained. If a stone is present the tube can be readily found, but, in the absence of a foreign body, it is well to remember that the converging ureters lie pretty closely over the lateral edges of the sacrum. The peritonæum is very thin and care should be taken not to tear it during the search. Danger of wounding the rectum is obviated by introducing a large sound by means of which it can also be pushed to one side. In the female the ureter is best reached through the vault of the vagina as it runs in the broad ligament for the last two or three inches of its course. The incision should be made backward and outward to keep within the layers of the broad ligament. After the vagina is divided the loose connective tissue can be pushed aside with the finger until the stone is reached. If the ureter is opened on its under surface there is little danger of wounding the peritonæum. If the stone is out of reach from the vagina and not accessible from above the sacral route can be used.

It is often a very hard matter to locate an impacted calculus although this is essen-

tial before selecting the point of incision. Rectal or vaginal examination will usually reveal the presence of a stone low down. When higher up the presence of a constant spot of great tenderness along the course of the canal, together with symptoms of obstruction may serve to localize the trouble. In the absence of definite indications Hall and Lane opened the abdomen, palpated the ureters and located small calculi. The hand inside subsequently aided extraction through a lumbar incision. A calculus could occasionally be crushed by the fingers or worked back to a more accessible point. The wound in the ureter is best left open as sutures are hard to apply in its thin walls and if they perforate the latter they will serve as nuclei for the subsequent concretions.—*American Journal of the Medical Sciences.*

LYSOL.—As a result of bacteriological investigations, Gerlach is led to conclude that watery solutions of the above are more effective than those of carbolic acid or creoline. This applies not only to pure cultivations but also to mixtures of bacteria. Besides it is much less irritating and poisonous than carbolic acid, creoline, or mercuric bichloride. The hands can be disinfected without the use of soap with a one per cent. solution and the walls of rooms can be freed of bacteria with a three per cent. spray. It is very cheap and surpasses all other disinfectants for sputa and stools.—*Zeitschrift für Hygiene.*

ETHER AND COCAINE IN LOCAL ANÆSTHESIA.—As subcutaneous injections of cocaine are so painful as often to preclude its use in nervous subjects, Schleith recommends that ether be first sprayed on the part for half a minute. Cocaine, one to three per cent. can then be injected over a larger area without pain. If the operation involves deeper structures, layer after layer may be anesthetized in the same manner as the patient complains of pain. Minor resections and other operations on bones may be performed in this way with but little annoyance to the patient.—*Deutsche Medizinische Zeitung.*

IMPROVED METHOD OF GRAFTING ULCERS.—Gill recommends the following method for grafting chronic ulcers of the leg: the surface is well cleansed for two or three days with boric acid fomentations; the granulations are then abraded just enough to cause oozing; the grafts are immediately applied, one to each square inch, and held in place by four or five half-inch squares of green protective, placed one on top of the other; the limb is encircled with a fold of gauze extending several inches beyond the ulcer, where it is fastened to the healthy skin with collodion; the ulcer is filled with boric acid powder dusted through the gauze and the whole done up in wet borated lint which is kept moist. The dressing is usually left alone for three days when the lint is removed and the ulcer irrigated. Boric acid is again dusted in and the lint reapplied and changed daily. On removing all the dressings at the end of ten days the grafts will have taken and grown considerably.—*London Lancet.*

THE "DRY POULTICE" IN THE TREATMENT OF EPIDIDYMITIS.—Brewer calls attention to a method of treating epididymitis recommended by Langlebert in 1889 which is carried out as follows: the inflamed testicle is enveloped with a thick layer of cotton wool; over this a sheet of thin rubber tissue is applied so as to completely cover the diseased organ and partly overlap, but not entirely enclose the healthy side of the scrotum; a snug gauze bandage and a suspensory complete the dressing. In this manner all the indications for the treatment of acute and chronic inflammatory affections of the testicle and epididymitis are fulfilled, viz.: heat, moisture, counter-irritation, immobility, compression and suspension. Langlebert was led to use this method after applying a similar dressing in a severe case of intercostal neuralgia involving the region of the left breast, for which the patient particularly requested that no blister or disfiguring local application be used. The pain disappeared entirely, but there was also an almost complete atrophy of the well developed mammary gland. Experiments on patients suffering from epididymitis were so successful that a suspensory bandage of cotton and rubber tissue was made, and this has been quite extensively sold and used throughout France. The writer has tried this dressing in some twenty-five or thirty cases of acute and chronic gonorrhœal epididymitis, in a few of painful tubercular disease of the epididymitis, and in one of genito-crural neuralgia. Pain was relieved, which however often occurs with any or no treatment, and, in every instance, rapid absorption of the induration followed each dressing.—*Journal of Cutaneous and Genito-urinary Diseases.*

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

GENITAL CHANCRES IN WOMAN.—Dr. Robert W. Taylor classes genital chancres in woman for clinical purposes as follows:

1. The superficial or chancreous erosion. This appears first on the mucous membrane, and is very liable to be mistaken for a ruptured herpetic vesicle, an abrasion or a scratch. It is so benign in appearance that its nature is frequently not determined at the first examination. It begins as a red spot, somewhat deeper in color than the mucous membrane on which it is seated. The secretion of this chancre is usually serous in character, or, when it is irritated, it may secrete true pus. Often no evidence of induration can be felt. A striking peculiarity of the chancreous erosion is its short period of existence. It frequently comes and goes without the knowledge of its bearer, and leaves no evidence of a cicatrix.

2. The scaling papule or tubercle. This lesion is found on the outer surface of the labia majora, upon the labia minora, upon the prepuce of the clitoris, upon the internal surface of the thighs, the inguinal folds, and the hypogastrium. It begins as a small, dull-red-colored papule, which may or may not be scaly and is usually not much elevated. It becomes brownish-red or purplish-brown in color, and has a sharply defined margin. It usually leaves a dark stain, and when irritated it loses its epidermal covering and becomes raw and exuding. In rare cases the scaling papular chancre develops around a hair, and when this occurs it is not uncommon to see two or three or even more of these chancres. All chancres of this variety are slow in disappearing.

3. The elevated papule or tubercle; *ulcus elevatum*. This chancre presents the appearance of a well-circumscribed flat or elevated lesion whose surface is similar to that of the chancreous erosion. It may be defined as a chancreous erosion in which the hyperplastic process has been more active and productive of much infiltration. The *ulcus elevatum* is seen upon the mucous surface of the labia majora and minora in its most typical form. It may become much hypertrophied, and around it may develop a greater or less amount of indurating oedema. It rarely shows marked induration.

4. The incrustated chancre. This is not uncommonly found upon the juxtapudendal cutaneous surfaces and indeed upon any portion of the integument. It has been stated that the incrustated chancres are not found within the area of the mucous membrane of the vulva, but it is not at all uncommon to find chancres in an encrusted state at the the fourchette, and rarely they are found upon the clitoris and the labia minora when these structures have come to look like integument. This incrustation forms upon an eroded surface; it begins as a thin, white film, presenting a glistening appearance, and this increases in extent and thickness until a species of false membrane is formed which is wrongly called diphtheritic membrane. Then again we find, though very rarely, the chancre called by Fournier chancre *multi-coloire*, or the *chancre en coeuvre*, in which the surface of the chancre presents a series of concentric zones of different colors.

5. The indurated nodule. This form of chancre, so common in men, is very rare in women. In men the syphilitic neoplasm or nodule, as a rule, circumscribes itself in compact form into a little mass; in women this new growth tends to diffuse itself more loosely into the soft mucous tissues.

6. The diffuse, exulcerated chancre. This is not infrequently observed in women of the lower order who are uncleanly in their habits and given to debauches. It presumably begins as a chancreous erosion and develops into the *ulcus elevatum*, and from this stage further develops. The appearance of this form of chancre varies. Sometimes it looks like raw beef, and at other times like an elephantine incrustated chancre.

As a rule all chancres of the female genitals are unaccompanied with pain.—*Journal of Cutaneous and Genito-urinary Diseases*, November, 1891.

At the Martin Polyclinic a systematic treatment of injections of iodine tincture is given in those cases of abrasion of the mucosa, to which is added to the primary affection of the endometrium a secondary affection of the neighboring tissues as well as of the uterus itself. The treatment is begun as soon as the acute stage is

passed. Pyo-salpingitis, purulent tube-ovarian tumors, and the last stages of uterine scirrhus are of course excluded. Out of the immense number of cases, the results in forty-five running cases were noted as follows: Seventeen cured, twenty-two much improved, five not improved, one discontinued treatment.—*Centralblatt für Gynäkologie*, No. 44.

PREMATURE LABOR AND CONTRACTED PELVIS.—In eighteen cases of induced premature labor for contracted pelvis at the Universitäts Frauen-klinik in Berlin, six were of flattened rachitic pelves, with a cong. vera of six and a half to nine and a half: three flattened but not rachitic pelves with cong. vera of seven and three-quarters to eight and three-quarters; nine generally and regularly contracted pelves with vera of seven and three-quarters to eight and three-quarters. Seven were operated on in the 36th week; four in the 37th; one in the 38th, and one in the 33d. The results were very favorable, 14 or 78 per cent. of the children being born alive.

As regards the mothers, one died on the eighth day from eclampsia; two febrile slightly; 15 had perfectly normal convalescence, no sepsis. An interesting point, which Oldhausen and Dohrn had already noted, is the large proportion of male children in cases of contracted pelves.

Five cases were operated upon for diseases of the mother; four for nephritis and one for chorea. Two mothers recovered and the other three died from the third to tenth month p.p. of nephritis. One child died on the seventh day p. p. Two were macerated and one died before the operation.—*Centralblatt für Gynäkologie*, No. 40.

STERILITY FROM OBESITY.—While the proportion of sterile marriages is only one to ten, in cases of obesity it becomes one to five. The causes seem to lie, on the part of the man, in the modification of the genital organs through the fatty deposit in the neighboring tissue and especially in the fact that in these cases the spermatozoa are much diminished in quantity. In very fat women there is apt to be either menorrhagia or amenorrhœa with catarrh of the uterine and vaginal mucous membrane and chronic metritis. There is often also, a troublesome eczema of the vulva which renders coitus painful. The prognosis is not unfavorable if active measures are taken to reduce the adipose.—*Centralblatt für Gynäkologie*, No. 38.

TREATMENT OF ALBUMINURIA DURING PREGNANCY AND PUERPERAL ECLAMPSIA.—At the Pinard clinic it is a rule to examine the urine at least every two weeks from the sixth month of pregnancy. Should any albumin be found the patient is put immediately upon a very strict milk diet and in order to avoid cold, is dressed in flannel and kept in a heated room. If œdema, backache and disturbance of vision occur a purgative is given, and if there is oppressed breathing, the chest is cupped and inhalations of oxygen given. Operative interference is reserved for those cases in which the albuminuria is intense, with anasarca, visual disturbances, nose-bleed and uræmic phenomena, and in those cases in which the albumin has not decreased during eight days of rigid milk diet, even if the other symptoms have disappeared. Should convulsions occur, chloral-hydrate is given and chloroform administered and continued as many hours as necessary. The delivery should be hastened by the application of forceps, turning or breech extraction. The antiseptics are very rigid.—*Centralblatt für Gynäkologie*, No. 38.

A FORTUNATE CASE OF RUPTURE OF THE UTERUS.—A 4-para, with contracted pelvis, who had had five premature deliveries, without operative interference, though difficult and long, in her sixth confinement, during a severe pain, experienced an extensive cervical rupture, through which the fetus escaped into the abdominal cavity to the right of the empty and contracted uterus. The patient was chloroformed, the fetus turned and extracted and the already detached placenta was manually delivered. A drainage-tube was inserted through the vagina into the rupture, secale given and cold applications made to the abdomen. On the second day peritonitis declared itself with a temperature of 40; this subsided on the eighth day and the convalescence was uninterrupted. At the end of the fourth week there was only a seam to be felt on the posterior vaginal wall.—*Centralblatt für Gynäkologie*, No. 38.

PHYSIOLOGICAL ACTION OF ERGOT.—According to experiments made in the physiological laboratory in Berlin, ergotin produces no contraction in the smaller vessels, but works specifically upon the peripheral ganglia of the uterus. It increases the reflex irritability, but that it can, in itself, produce tetanus is false. In

inertia of the uterus, with membranes still intact and uncontracted pelvis, ergotine can be given without hesitation. There has also been a misunderstanding in regard to the power of ergot to contract the vessels and arrest hæmorrhage, which, according to these investigations, is due merely to the reflex action of the uterine and vaginal contractions, and its real power of arresting hæmorrhage lies in the quality it imparts to the blood of quick coagulation.—*Centralblatt für Gynäkologie*, No. 38.

EXPERIMENTS WITH ICHTHYOL.—The clinical experiments with ichthyol have not been as satisfactory as was expected, but worthy of notice. It will be used mostly in chronic, inflammatory affections of the pelvic organs. The best results will be found in oöphoritis and periophoritis rather than in slighter cases of parametritis. It has very little effect in salpingitis. It may be noted that in two cases a general erythema appeared after its use and in one case reappeared the second time.—*Centralblatt für Gynäkologie*, No. 41.

ACTION OF ICHTHYOL.—According to Dr. Oberth of Vienna, ichthyol does not possess any remarkable absorbing power in inflammatory conditions of the parts that surround the uterus, nevertheless he is sure that to a certain degree the effect is to allay inflammation and pain. The use of ichthyol, especially in the form of ten per cent. ichthyol-glycerine tampons, appears to be indicated in sub-acute and chronic parametritis, pelvic peritonitis and swelling of the uterine appendages, when the subjective conditions are such as not to call forth a feverish exacerbation of the inflammatory condition.—*Jahrbücher*, Band 232, No. 10.

RUPTURE OF THE UTERUS.—There were eight cases of rupture of the uterus at the Policlinic in Prague from 85-90, of which five were incomplete and cured with tamponing, three incomplete ending fatally. Of these two underwent laparotomy, and the two were tamponed. The following treatment is suggested in cases of partial rupture: Rigid disinfection, and then through external manipulation bring the edges of the wound as near together as possible and endeavor to prevent hæmorrhage. The uterus should be maintained in this position at least an hour. Then a cautious examination of the tear should be made, and a dressing of iodoform gauze pressed into the wound. Between the strips of gauze place a drainage-tube, and tampon cervix and vagina. Ice-bag on abdomen, opium for the bowels, and catheterization. The tampons may be gradually withdrawn on the 9-10 day.—*Centralblatt für Gynäkologie*, No. 38.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

AN AUDIBLE AURAL MURMUR.—Dr. S. Szeues, of Pesth, has reported the case of a girl, 10 years old, who complained of a constant "ticking" in the left ear. The power of hearing was normal in each ear, but the drum membranes were cloudy and thickened in spots. The murmur could be heard plainly at a distance of about five inches. It had the character of a snapping sound, and was heard from 120 to 136 times a minute, whether the child was awake or asleep. It was not synchronous with the heart's action, and was supposed to be caused by rhythmical spasmodic contractions of the tensor tympani, or of the muscles of the soft palate.—*Centralblatt für Klinische Medizin*.

REMOVAL OF A FOREIGN BODY FROM THE TYMPANUM.—In a case under the care of Gruber (*Monatschrift für Ohrenheilkunde*, May, 1891), it was necessary to adopt operative measures. The patient had suffered great pain for three weeks, owing to previous attempts at removal of the body (a rough wooden knob, 5 millimeters in diameter). There was redness and swelling at the attachment of the auricle; the meatus was narrowed to a mere slit, filled with thick, yellow pus, and no speculum could be introduced; but, on careful probing to the depth of about 4 centimetres, the presence of the foreign body was evident to both surgeon and patient. On catheterization, air appeared to reach the tympanum, and no perforation sound

was heard. The symptoms became more severe; the introduction of pledgets of cotton wool dipped in cocaine solution made the pain still worse, and operative procedures were adopted. The auricle and soft parts were detached above and behind, but it was still impossible to remove the foreign body. The outer portions of the upper and posterior walls of the meatus were carefully removed by means of chisel and mallet, and the deeper portions of the posterior wall by means of a sharp spoon, working backwards. The foreign body was then loosened, and easily removed with forceps.

SUBCONJUNCTIVAL INJECTIONS OF CORROSIVE SUBLIMATE IN EYE DISEASES.—Darier (*Arch. d'Ophthalmologie*, September and October, 1891), reports a series of cases from Abadie's clinic, in which the treatment indicated in the title of this paper was adopted. This method of treatment seems to have grown out of the intraocular mercurial injections suggested by Abadie two years previously, for sympathetic ophthalmitis, and practiced by Raymond and others. The syringe employed is Pravaz's, with the needle modified so that it penetrates the conjunctiva easily and without tearing. The eye is first cocainized. Care is taken that the syringe is perfectly aseptic, the instrument being kept, when not in use, in 5 per cent. carbolyzed glycerine. Darier has found a $\frac{1}{10000}$ solution of the perchloride in boiled water preferable to stronger solutions, and injects from $\frac{1}{20}$ to $\frac{1}{10}$ of a cubic centimetre; the latter quantity contains 1 milligramme of the sublimate. The injection is followed by some œdema of the conjunctiva, and more or less pain of a burning character. The first two injections are given at two days' interval, the third and fourth three or four days later. The continuance of the injections will depend upon the effect produced and the individual tolerance to the treatment. In cases evidently of a syphilitic nature mercury should also be administered in other ways. The records published by Darier include cases of iritis and irido-cyclitis, keratitis of several varieties, choroiditis, retinitis, and inflammation and atrophy of optic nerves. The results he considers decidedly encouraging in all except the optic nerve cases.

PREVENTABLE BLINDNESS IN THE YOUNG.—Dr. C. D. Conkey, in discussing, in the *Northwestern Lancet*, this important and neglected subject, reaches the following conclusions:

1. That the largest proportion of blindness in the young can be prevented.
2. That the majority of cases of blindness develop in the practice of the general practitioner, in the course of the invasion of the grave diseases of childhood, or as a sequence to these, or as a result of a contagious leucorrhœa in the mother.
3. That to successfully prevent them, prophylactic measures should be adopted in all cases where danger is suspected, or where the eyes show a tendency toward inflammatory action.
4. That the physician should be sufficiently acquainted with eye diseases to treat them skilfully when the eye becomes invaded.
5. After all severe attacks of the diseases of childhood the patient's sight should be carefully tested before he is discharged as cured.

If these precautions were carefully observed, he is confident that the percentage of blindness would be greatly reduced among the young, and to the many thousand children that yearly become blind would be preserved this most precious of all the senses.—*The Medical and Surgical Reporter*, December 12, 1891.

MYDRIATICS.—Dr. Roberts Bartholow, of Philadelphia, in a few observations on the mydriatic alkaloids (*Medical News*, December 12, 1891), states that if he were asked to indicate where his preference lay in selecting a mydriatic for maladies mentioned below, his reply would be as follows:

For eye operations and refraction work, homatropine.

For the treatment of eye-inflammations, atropine.

For maladies attended with insomnia, neuralgia, nervousness, various kinds of nervous trembling, as chorea, senile trembling, paralysis agitans, muscular agitans, muscular agitation and unrest, hyoscine or hyoscyamine.

For mental diseases of a depressing kind, melancholia, etc., puerperal mania, with or without albuminuria, duboisine, hyoscine, or hyoscyamine, but especially the first named.

For acute mania, paranoia, mental disorders with much muscular agitation and frequent and protracted muscular restlessness, hyoscyamine or duboisine.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

TREATMENT OF SENILE CATARACT.—An analysis of a large number of cases of senile cataract treated by the late George S. Norton and his brother, Dr. A. B. Norton, now published by the latter makes a very good showing for the value of homœopathic treatment of cases of this character. Beneficial effects were noted in the majority of cases.

Of all the remedies used, *causticum* proved to be of the most value. The principal indications for the remedy are a feeling as if there was sand in the eyes; sensation of pressure in the eyes; heaviness of the lids; burning, itching of the eyes with a desire to keep them closed; photophobia, flashes of light before the eyes; winking and twitching of the lids.

Calcarea phos. appears to be the next most useful remedy. It seems to be especially indicated under the following conditions: headaches, especially of the right side; pain around the right eye; aching pain in the right eye; tired feeling of the right eye; eyes feel stiff and weak; dizziness; rheumatic pains.

Sepia was given for the following symptoms; eyes feel weak, worse toward evening, and better in the middle of the day; some sharp pains in the eyes; heaviness of the lids; twitching of the lids; smarting of the eyes, relieved by eating; headaches which are worse morning and evening; perspires very freely, worse morning and evening. The morning and evening aggravation seems to be characteristic of *sepia*. It is a useful remedy in the cataracts of women.

Phosphorus is indicated when there seem to be colors before the vision; black floating spots before the eyes; flashes of light, and the concomitant symptoms of the drug.

Naph. line was used in a few cases because it has been known to produce cataracts in animals; success with it, however, has been very indifferent.

Iodoform has been used on the recommendation of Dr. King, of Washington; but the time has been too short as yet to speak positively of the results obtained.—*North American Journal of Homœopathy*, December, 1891.

CHLORIDE OF GOLD IN CHRONIC TOBACCO POISONING.—Dr. E. M. Hale reports the case of a man who had indulged so freely in tobacco that he became exceedingly prostrated, and developed a condition almost akin to incipient delirium tremens, and with severe gastric irritation, pharyngitis, and great cardiac weakness and irregularity. He had tried a number of times to give up the habit, but suffered from the most distressing insomnia, irritability of mind and insatiable craving for tobacco. After trying several remedies in vain, Dr. Hale prescribed the chloride of gold and sodium, one-sixtieth of a grain before each meal and on going to bed. A complete recovery followed. The author has also used the remedy in the treatment of the morphia habit. It does not do away with the desire for morphia at once, as it does in the tobacco habit.

The secondary symptoms of gold resemble the disorders under consideration. They are depression of spirits, plaintive, tearful melancholy, desirous of death, restless, anxious, timid, disagreeable, getting into quite a rage at the slightest contradiction; wanting to quarrel and going into the violent passions, or apathetic, indifferent, with complete loss of will and memory. Gold causes serious defects of vision, aneurosis, anemia of the optic nerve, dimness of vision, hemiopia, double vision, and asthenopia. The symptoms of the throat, mouth and tongue, also the gastric symptoms, closely resemble those of tobacco when used to excess. It will cause impotence and sterility by its secondary action. The cardiac symptoms bear

a striking resemblance to those of tobacco. Witness the extreme tightness of the chest, with difficult breathing at varying times, great weight on the chest, in the region of the sternum. Pain in the heart, with constrictive sensation, with pain running down the left arm; wakes with intermitting, feeble beating of the heart. Waking with palpitation of the heart he feels the throbbing all over; a restless anxiety arising from the region of the heart, he cannot remain quiet; arms and legs numb, and as if asleep, with a weary aching.

Wakefulness, insomnia, or the sleep is broken by starting, waking as if frightened; moaning and crying in sleep, with unpleasant dreams. The "persistent coldness of the hands and feet with dampness; the constant internal chilliness, and inability to keep warm; the great liability to catch cold, great sensitiveness of the body to all kinds of pain, so that the very thought of pain is almost the pain itself." For all the conditions above enumerated, we must use not less than 1-100th of a grain several times a day.—*New Remedies*, January, 1892.

PRACTICAL OPERATION OF A REVISED MATERIA MEDICA.—Dr. R. W. Mifflin, a member of the Baltimore Medical Investigation Club, reports several cases treated by remedies prescribed on the indications afforded by the pathogenesis as revised by that Club. CASE I. was that of a widow, æt. 37, an actress, suffering from headaches. The headaches were not always of the same kind—sometimes they appeared in the morning, sometimes in the evening, and at times at night after the play; but the pain was a sore pressing sensation on the fore part of the head particularly. There was with each attack sickness of the stomach, sometimes expressed as "perfectly deathly," and at all times she had vomiting of food and mucus with heat and fulness in the stomach. The tongue was persistently coated a dirty yellowish color, not a thick covering but thinly spread over it. The Investigation Club's synthesis brings out clearly that nausea with or without coated tongue is the great characteristic symptom of ipecacuanha; but our materia medica gives the symptom thus: "Vomiting with a clean tongue." Ipecac 3 was given, and complete cure followed.

CASE II.—Mr. W. Y. came under treatment for headache which dated from a fall he had had some time before from a wagon. Arnica was at once thought of, but before prescribing the remedy, the pathogenesis of that remedy as revised was referred to, and the following symptoms of the case in point were found: Drowsiness, and when he does fall asleep, he is disturbed by very slight noises and wakes. The bowels are nearly always loose, three or four stools daily, with more or less pain at the time or just before the evacuation. No appetite to speak of at any time, occasionally nausea and pain at the stomach, and usually considerable flatus; feels tired almost all the time, and depressed in spirits. Although the headache was described as thick headed, the actual pains at times he experienced were in the front part of the head between the eyes, which in the reconstructed arnica has been found to be characteristic of six provers. Accordingly arnica 3 was given. A cure followed, although convalescence was interrupted by an acute attack of inflammatory rheumatism.

CASE III.—Gelsemium 3 cured very promptly a case of ptosis complicated by paralysis of the face.

CASE IV.—A fat, flabby-tissued lady of 30 years, a choir singer, had an intermittent huskiness in her voice, which at times resulted in complete aphonia. At this time she was unable to sing her soprano parts. She was conscious of having taken a severe cold, and there were present the coryza and the pains, soreness and aching of an influenza. There were more or less soreness and stitching pains all through the chest; pain and soreness in the larynx and trachea, especially when taking long breaths. Some rheumatic pains off and on in the muscles of the back and scapular region, photophobia and watery eyes, conjunctivitis, flying neuralgic pains in both sides of the face. Cansticum 3 was prescribed. After continuing the remedy two or three times daily for five months a complete cure resulted.—*Southern Journal of Homæopathy*, December, 1891.

CASE OF CEREBRAL CONGESTION SUCCESSFULLY TREATED BY FERRUM PHOSPHORICUM.—Dr. Bernardo Epinosa, of Bogota, Colombia, S. A., communicated the case of a patient, 30 years of age, who, after an excess in eating and drinking, was suddenly exposed to a cold wind from the Panamas. He immediately began to feel sick, was seized with headache and a pain running from the left ear to the nape of the neck; movements of the right hand and arm became difficult; slight indigestion. The patient rode to the doctor on horseback, and dismounted with ease. The pulse was found to be rapid, full, and hard. *Ferrum phosphoricum*

was administered in some water, and several doses given to supply him during the night. The writer gave him hopes of recovery. He attempted to remount, but found it impossible. Imagine my surprise when, the next morning, at 8 o'clock, before reaching the door of my office, I was met by the gentleman, who lifted his right hand and said: "Señor Doctor! I am already well!" Indeed, there remained but a slight involvement of the shoulder muscles; he could lift his right arm with ease. All his functions were performed with regularity. He informed me that he took the medicine but once during the night. I examined his pulse and found it still somewhat full and strong, for which I gave him *aconitum napellus*, and advised him to be temperate in his meals.—*La Homeopatia*.

AVENA SATIVA AND ITS INDICATIONS.—In a paper bearing this title, Dr. H. E. Russel says that *avena sativa* is almost as frequently indicated as *aconite*. It is pre-eminently an anti-neurotic, quieting the nervous system to a remarkable degree. Its special sphere of action seems to be the male sexual organs, regulating the functional irregularities of these parts as much as any drug can. It is a most useful remedy in all cases of nervous exhaustion, general debility, nervous palpitation of the heart, insomnia, inability to keep the mind fixed upon any one subject, etc., more especially when any or all of these troubles is due to nocturnal emissions, masturbation, over-sexual intercourse, and the like. It is one of the most valuable remedies for overcoming the morphia habit. When morphia has not been used in doses of more than four grains daily, it may be abruptly discontinued, and the *avena* substituted. If a larger quantity has been used, then the dosage may be diminished, and the *avena* given as before. The dose of *avena* is always an appreciable one, fifteen drops three or four times daily, meeting most cases. If given in overdoses, it produces pain at the base of the brain. It should never be given in larger doses than twenty drops to begin with.—*North American Journal of Homœopathy*, November, 1891.

CYCLAMEN IN HEEL PAINS.—Dr. George Royal, writing to the *North American Journal of Homœopathy*, says in the fall of 1883 a fellow-practitioner came into his office and told him he had suffered with soreness of the heel for over three months. The soreness seems to be in the bone; was worse while sitting or standing. It was not noticed much when walking. *Rhus tox.*, *kali bi*, and *phos. acid* had been tried without relief. After looking up the symptoms in Allen's *Symptomen Register*, *cyclamen* 30 was prescribed. It cured in one week. About three weeks ago, a man came to him with the same symptoms. The only aggravation was while standing. The same remedy cured in three days.

CARBO VEG. SYMPTOMS.—Dr. A. M. Linn reports the following cases confirming symptoms of *carbo veg.* Case I. Mrs. G., as often as once a fortnight suffers from large accumulations of gas in the stomach and bowels. This condition usually follows the ingestion of a meal, even coming sometimes before the meal is completed. The distress which these attacks occasion is usually very severe, and leaves the patient much prostrated for several days. Any close application, any fatigue or unusual excitement or worry tend to produce an attack. During an attack she rolls on the bed or floor, or assumes any position for temporary relief. She is much distressed for breath, wants all the doors and windows thrown open, wants to be fanned. The heart's action becomes somewhat excited and irregular. No organic lesion exists. Mental depression, irritable, impatient, complaining of burning and sourness of eructations. Subject to these attacks for five years, and they are still increasing in severity and frequency. *Carbo veg.* 3x was prescribed. The result was all that could be desired.

Case II. Mrs. T., æt 66, spare habit, blonde, presented a case similar to case I. Frequently after a meal and sometimes in the interval, and without warning, large quantities of gas would accumulate in the stomach and bowels. The walls of the abdomen became tense and resonant on percussion; breathing difficult and labored; lips blue, hands and feet cold. The distended abdomen crowded upon the diaphragm and limited the lung space; heart lost force and vigor, and an active congestion of the lungs followed. These congestions were often intense and so severe as to threaten the life of the patient. They invariably began with the accumulation of gas in the abdomen. During an attack the distress was extreme, the dyspnoea was intense and the suffering very severe. During this stage the patient expectorated considerable quantities of frothy, bloody mucus. Attack lasted from half an hour to four hours. As soon as gas was eructated relief followed. *Carbo veg.* was exhibited with the happiest results.

Case III. was that of an old minister suffering from atonic dyspepsia. The tardy digestion permitted the generation of considerable quantities of gas in the intestinal tract. At such times the heart lost force, and also became somewhat irregular. He complained also of burning in the stomach, hot and sour eructations, impaired and retarded digestion, shortness of breath, labored action of the heart, causing much apprehension; sense of distension of the abdomen, mental depression and despondency. *Carbo veg.* 3x was prescribed. The remedy acted like a charm, the attacks remaining away for a period of six months.—*North American Journal of Homœopathy*, November, 1891.

CACTUS GRANDIFLORUS IN HEART DISEASE.—Dr. Solon Abbott reports the following case much benefited by cactus, although all the prominent symptoms of that drug were absent. Mrs. D., aged 62, has suffered from valvular disease of the heart for several years. The disease had made but slow progress, the swelling of the legs extending only a little above the knees. In January, 1890, she had an attack of grippe, causing a marked aggravation of the heart trouble. The body became bloated to quite a degree, the urine was scanty, and the breath very short. The death of the patient was expected almost hourly, but she began to improve, and remained comfortable for several months. The dropsy remained, though somewhat improved. In December she took a slight cold and all the symptoms returned with renewed force. The body was very badly bloated and the hands and face swollen. The urine was scanty and high colored, breath short, the heart laboring very hard, and the patient unable to make the slightest exertion. The pulse was slow and intermittent. There was no pain. Various remedies had been tried, principally digitalis, but no benefit resulted. *Cactus* 2x was now given, and improvement began almost immediately, urination being very profuse. The dropsy disappeared entirely, excepting an occasional swelling of the ankles. She now feels better than she has any time for the past five years.

In the discussion that followed, Dr. F. A. Gushee said that in a case of angina pectoris, in which aconite had failed to give relief, *cactus* 30 prescribed on symptom "sensation as though a swarm of hornets were going from the pectoral region to the head," proved successful.—*Transactions of the Maine Hom. Society*, vol. v.

ARSENICUM ALBUM IN CANCER.—Dr. A. K. P. Harvey reports a case of an epithelioma which he treated by arsenicum. The patient was a man aged 69, naturally strong and hardy, but much prostrated and broken down from severe and long continued suffering. He had epithelioma of the conjunctiva and surrounding tissues. The ulcer had started at the outer canthus of the left eye, and extended downward and backward as far as the zygoma, well down upon the cheek, and upward deeply beneath the orbital arch. The ulcer was dressed twice daily by first cleansing thoroughly with carbolyzed linseed oil, then applying the 2x trituration of arsenicum by dusting over the exposed portion of the ulcer, while that portion beneath the lid and orbital arch was first treated to a solution of the remedy, followed by the application of the powder. After three or four weeks the part began to heal, and gradually closed up after three months of constant and untiring attention, leaving an indurated mass above the cicatrix. The sore again opened in three weeks, when treatment was renewed, and was again successful.—*Transactions of the Maine Hom. Med. Society*, vol. v.

FATAL PROVING OF PLUMBUM.—Dr. J. Murray Moore calls attention to a case of lead poisoning reported in the daily press. The patient was a man aged 51 years, who committed suicide in his fowl-house by hanging himself to a beam. For some time past he had been a sufferer from severe lead poisoning, which had made him very low-spirited and restless.—*Homœopathic World*, December, 1891.

CARBOLIC ACID.—Dr. A. I. Harvey has cured three cases of diabètes mellitus with carbohc acid. It is only efficacious in the early stages and in young and middle aged persons. One of its leading characteristics is a tired feeling, which seems to result from a condition of physical prostration.—*Trans. Maine Hom. Soc.*, vol. vi.

NATRUM SULPH. has served Dr. Monroe well in the treatment of chronic diarrhœas of long standing, characterized by profuse gushing stools early in the morning. It seems as well to suit catarrhs generally of mucous membranes characterized by a tendency to profuse secretion of mucus.—*Southern Journal of Homœopathy*, December, 1891.

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HAS IT BEEN AN OVERSIGHT?

BY M. W. VAN DENBURG, A.M., M.D., FORT EDWARD, N. Y.

(Presented at the Forty-first Annual Meeting of the Homœopathic Medical Society of the State of New York.)

Is there a therapeutic law, plainly deducible from the facts alleged in allopathic materia medica, if the same methods are applied that are used to demonstrate natural laws in other departments of investigation?

This is not, nor can it be made, a hackneyed question until it has been decided at the bar of scientific deduction. Too much is at stake in the welfare of the race, in the advancement of the science most important to humanity, the science of preserving life, to dismiss this consideration with a shrug, a smile, or a sneer.

If our allopathic *confreres* have been blundering along where they might have walked safely, confessing (as they have been and still are by the mouths of their best men) that there is no general guide or rule for the administration of drugs, and if such a law has lain unrecognized upon the open pages of their text-books for years, if not for ages, awaiting for its demonstration only the application of the same general rules that apply to the demonstration of natural laws in other departments of scientific research, then surely the most effective way of meeting their objections is to convince them of the existence of such a law out of their own mouths. This must be

done, not in one or two, but in multiplied instances; not occasionally, but repeatedly and continually, until they are forced to acknowledge at the bar of public opinion the futility of denying its existence.

In this line was prepared the "Study of Arsenic," presented to the International Homœopathic Congress, at Atlantic City, in 1891. In further illustration of the method, this paper is now brought forward for your consideration.

All the facts alleged are from allopathic sources, from the recognized authority, Stillé's *Therapeutics and Materia Medica*.

Let me beg your indulgence to call attention to some general principles laid down in the paper on "Arsenic," to which reference has been made.

First, the general principles laid down by Herbert Spencer for finding a natural law.

He says: "Though we can never learn the *nature* of that which is manifested to us, we are daily learning more completely the order of its manifestation."

"The order of manifestation is but another expression for that constant course of procedure which we call law." (Spencer's *First Principles*, Part II., chap. 1, "Laws in General," 1864.)

In chemistry, when sulphuric acid and metallic zinc are brought in contact for a sufficient length of time, sulphate of zinc will be produced. This is a "constant course of procedure."

In physics, when two metals are connected by a copper-wire or other conductor, and placed in a solution or fluid, which acts chemically upon one of them and not upon the other, a current of galvanic electricity is generated which will pass over the connecting wire in a certain direction. This is an "order of manifestation" always present.

At or near the earth's surface, all unsupported bodies tend to move or fall towards the earth's centre. This is a "constant course of procedure," the "order of manifestation" of the phenomena of falling bodies.

Wherever we find a "constant course of procedure," we find a natural law.

Two series of phenomena are set forth by Stillé, as by all allopathic writers on materia medica. The one is termed "the action of the drug on man;" the other, "the remedial employment of the drug."

What we most desire to know, what every physician desires to

know, is, can any "constant course of procedure" be laid down for the administration of drugs?

The allopathic answer to this is: there is no "constant course of procedure" known.

The problem seems not to have been approached from the side of scientific experiment, guided by the scientific method.

There has been plenty of experiment in a desultory way, but without the application of the scientific method. The experimental side of drug action has been, and still is, being developed, though not with the careful precision the subject demands. It is engaged in noting only the most prominent, which are far from being always the most important facts in the application of the drug in medicine. Out of this array of experimental facts, each author has felt at liberty to choose or reject, as his own discretion might dictate. With all this, the question seems never to have seriously suggested itself, what is the relation, if any, which exists between the phenomena of the "action of the drug on man," and the "curative action of the drug" in disease.

Obviously, the only way to find out is by comparing the two series of phenomena.

INTRODUCTION.

When I first proposed to write for this meeting, I expected to treat of the group of drugs called by Prof. Stillé antispasmodics.

Neither the time at my command, nor that allotted to a paper at this meeting, would suffice to do justice to the ground as laid out.

I, therefore, began with the first drug on the list, simply because it was the first; not that it illustrates the points in investigation here raised better or as well as some other drugs in the same arbitrarily constituted group mentioned above.

For this purpose we now turn to the study of *asafœtida*, all the facts used being, as stated, from Stillé.

It may be well to say at this point that *all* symptoms given by our author under the "action of the drug on man" have been quoted here, as also *all* the cures reported and all the diseased states benefited, and for which it has been recommended in "its remedial employment." On this account, all failures of the two series to conform will become apparent.

In the digestive sphere, *asafœtida* causes:

"Burning in the fauces;"

"Impaired digestion;"

- "Enfeebled digestion;"
- "Alliaceous eructations;"
- "Oppression and fulness of the stomach;"
- "Nausea and vomiting;"
- "Distension of the abdomen and discharge of fetid flatus;"
- "Colic and burning in the abdomen;"
- "Increased peristalsis of the bowels;"
- "Strong inclination to stool;"
- "Diarrhœa;"
- "Thin and repeated evacuations;"
- "Removes intestinal worms."
- "It also causes increased secretion of the liver."

Asafœtida cures :

- "Impaired digestion;"
- "It augments the appetite;"
- "It improves the digestion;"
- "It improves the morbid secretions of the mucous membranes and expels intestinal worms;"
- "It cures distension of the abdomen by promoting the discharge of flatus;"
- "It cures hypochondriasis by the direct action of the drug on the digestive function, which is the starting-point of the disease."

We note here that no disease is here said to be cured by the drug that has not its direct counterpart in the diseased state caused by the "action of the drug on man." Even the expulsion of worms falls under this head, since it is conceded that intestinal worms are the result of an impaired state of digestion, and not the associates of the healthy human being.

Upon the respiratory system, the action of *asafœtida* causes :

- "The pulse and the respiration to become slower;"
- "The pulmonary exhalations to become increased."

(Note here in the last the careless and indefinite method used in describing the action of the drug.)

Asafœtida cures :

- "Chronic catarrh, with or without spasmodic dyspnœa;"
- "When the wheezing is considerable and the expectoration difficult from the general debility, or the cough spasmodic, much benefit may be derived from the use of the drug."

In the sphere of the nervous system, *asafœtida* causes :

- "General malaise;"
- "More or less flying pains in the head;"

"Various nervous and hysterical phenomena ;"

(Again we regret the imperfect report of the action of the drug as expressed in the description of the hysterical phenomena.)

"Occasionally, asafoetida increases the sexual desire ;"

"It tends to hasten the menses ;"

Cures made by asafoetida :

"General debility is cured by the property of this drug of imparting vigor without exciting ;"

"This drug is one of the most valuable agents that can be employed in the treatment of hysterical cases ;"

"In true epilepsy it is perfectly useless ; but in hysterio-epilepsy it is reported to have cured one case ;"

"In nervous apoplexy, or that form which seems to consist in simple congestion of the brain, it deserves a prominent place ;"

"The spasmodic affections of girls, at the age of puberty, are frequently cured by the establishment of the menses ; the emmenagogue properties of asafoetida may therefore become the *indirect means* of removing these nervous disorders."

Again note—no *cure* is here mentioned as effected by this drug (except the indirect cure), that is not like a diseased state caused by the drug in its action on man.

But a still stronger case, in the same direction, is made out by our author. Look on these two pictures :

Asafoetida causes :

"Impaired digestion ; general malaise ; enfeebled digestion ; colic and burning in the abdomen ; distension of the abdomen (Jorg says enormous distension of the abdomen, and Jorg is the authority quoted by our author) ; and various hysterical phenomena."

Says Stillé :

"In that torpid condition of the bowels which is commonly associated with general debility, when the digestion is imperfectly accomplished, and severe attacks of colic supervene ; when tympanitis, sometimes of an immoderate degree, oppresses the breathing and becomes the exciting cause of an hysterical attack, when, at the same time, there are signs of chlorosis, or that disease is fully developed, a combination of symptoms is presented which causes extreme suffering to the patient and great annoyance to the physician. No single medicine is more useful than asafoetida in removing this."

Can it be possible we are not reading the prescription of a dyed-in-the-wool Hahnemannian homœopath, one of the straightest of the sect ?

When Stillé talks of a "combination of symptoms" "removed by a single remedy," and when every symptom in that combination, with the exception of one (which one may, or may not, be present), is found in the list of symptoms caused by the action of the drug on man, what more could Hahnemann himself have advised in such a case?

Surely, if the advice of Hahnemann, that "when the totality of the symptoms of the patient are matched by symptoms of a like degree and kind, caused by the action of a drug on the healthy human organism, then that drug will assuredly cure the patient"—if this needs confirmation, Stillé furnishes as strong testimony for it as sound reasoning and candid thinking could ask.

We note, therefore, in applying Spencer's law, that the "order of manifestation" of the curative powers of this drug is shown by "the constant course of procedure" in effecting cures with *asafœtida*, as set forth by Stillé's *Therapeutics*, in those diseases, without exception, which are strongly similar to the morbid states produced by the action of the drug on man." And that *no other cures* are recorded or recommended, save in one case only, where the author distinctly declares the cure to be "indirectly" the result of the action of the drug.

WOMEN IN MEDICINE.

BY MILLIE J. CHAPMAN, M D., PITTSBURGH.

(Address before the Allegheny County, Pa., Homœopathic Medical Society, January, 1892.)

WOMEN entered the medical profession through the department of midwifery. Not only the sacred Scriptures but all profane and classic authorities, Plato and Aristotle, Plautus and Terence attest the fact that this practice was anciently and originally confined to their hands. In Egypt and Arabia, in Chaldea and Greece, in Persia and Rome, woman ministered to woman. Long after the fall of Rome, woman exercised this profession there. During the Middle Ages they alone practiced it in France; and it was not till after the accession of Henry IV. that men accepted its privileges.

More than a dozen names of women practicing midwifery have come down to us from the period preceding the Christian Era. At an unascertainable date the Areopagus passed a statute forbidding women and slaves to practice the art in Athens.

Agnodike, the young daughter of Hierophilus, entered the lists with the physicians of the time. Her father sustained and instructed her in her career. Her success and popularity aroused hatred. Her accusers cried: "Let her be condemned!" But the women of Athens, who watched every stage of the proceedings with absorbing interest, rushed in a body to the Assembly, requiring her to be set free. She was released, and a law immediately passed empowering all free-born women to learn midwifery. Four other names will possess a general interest: Aspasia, wife of Lysicles, not the Aspasia of Pericles; Artemesia of Karia, Cleopatra and Elpinike. The success of those women, like these of to-day depended, not upon differences of preparation so much as on native difference in tact and manipulative skill.

The accounts of Aspasia are clear and satisfactory. Artemesia was the queen who assisted Xerxes so boldly at the battle of Salamis. Yet she was tender and efficient at the bedside of the sick. Cleopatra, of Egypt, found time among her various undertakings to write several books; one was a treatise on midwifery. In Greece, Elpinike, the daughter of Cimon and sister of Miltiades, is known to have pursued the same profession. So sacred was the position at this era, that queens, princesses, and priestesses at the altar did not hesitate to perform its functions. And long after, at the Court of France, when the purity of Joan of Arc was called in question, it was not a college of surgeons, but five women of the noblest blood who made the legal deposition consequent upon examination which wiped away the aspersion.

Trotula is the earliest among modern midwives. She was born at Salerno in the middle of the thirteenth century. She published several works, one of which is said to have produced an era in medical literature. In the fifteenth century two women deserve especial notice. The first, Madame Perrette, who was sworn into office in 1408. After a life of singular usefulness, the superstition of the time caused her to be imprisoned and condemned to death for sorcery. But Perrette had made herself too valuable. The ladies of France demanded her services and she was pardoned.

The second was Madame Gaucourt, one of the examiners of Joan of Arc later in the century.

Four names interest us most of the women of the sixteenth century:

1. Madame Francoise, the midwife of Catharine de Medicis. The first female lecturer upon obstetrics of whom we find any record.

She lectured to large classes of both sexes. An early example of co-education without any intimation of an unfavorable result.

2. Olympia Morata, born 1526. She was highly educated, and aside from her professional duties became professor of Greek; later, married a physician, whom she accompanied to his home in Germany. It is stated that she prepared the lectures he delivered at Heidelberg. The letters of her husband to his friend after her death prove that she was not the less a tender woman and devoted wife because she was also an accomplished scholar and midwife. I should weary you by mentioning the long list of names of women living to-day equally gifted and equally successful. But I cannot forbear a reference to a brilliant example of an educated woman who is a loving, devoted wife; a willing, faithful mother. I refer to Phoebe J. B. Waite, the Dean of the Woman's Medical College of New York City. To this may be added that of Harriet J. Sartain, of Philadelphia, and Caroline B. Winslow, of Washington, D.C.; and last, but not least, that of Myra K. Merrick, of Cleveland, Ohio. A woman who graduated in medicine in 1852 with the honors of her class. Shrinking from public work or notoriety, she has performed faithfully the home duties of a mother, and at the same time accomplished a mountain of medical work, and to-day is a martyr to the profession.

3. Next of the sixteenth-century women was Madame Perrone, who contributed all the obstetrical observations to the works of the eminent French surgeon, James Guillemeau.

4. Louise Boursier Bourgeois, born 1580. She studied late in life, and was appointed to attend the queen of France. She published many valuable works, among them a wise letter to her daughter, whom she entreates "to continue to learn to the last days of her life." A contemporary poet, with the extravagance of his nation, says: "That to praise her properly would require the pen of an angel and the mind of a god."

In the seventeenth century three out of the thirty women have claims for remembrance because of their literary work upon medical topics. They are La Marche, Seigmunden and Boucher.

Sebastian Badus, physician to Cardinal Lugo, in an essay publishes the fact of the following memorable service to the practicing physician: A Spanish lady, the Countess de Cinchona, wife of a viceroy of Peru, was attacked by the fever of the country. She insisted upon trying the Indian remedy, Peruvian bark, which had not then attracted the notice of any European. She was speedily cured, and on her return to Europe in 1632 she made great exertions to

spread the knowledge of the new medicine, of which she carried home a great quantity. She gave it to Cardinal Lugo, who carried it to Rome in 1649. Its use spread through Europe under the name of quinquina. The Jesuits at the missions induced their Indians to collect it, and exported it as "Jesuit bark." More than a hundred years after this the great Swedish naturalist, Linnæus, published a *materia medica*, and gave to the genus of plants which furnish this bark the name *cinchona* in memory of the countess' services.

As you all know, it was at a later day, in the use of a preparation of Peruvian bark, that Hahnemann observed, if administered to those in health, it produced a fever similar to the one it was given to cure. From this was evolved our law of similia, the only sure guide for prescribing remedies known to scientific medicine. Hence, we are indebted to the discoveries of this woman, supplemented by the wisdom of Hahnemann. This grand man was encouraged, and his labors increased tenfold, by a great woman, Madame Hahnemann.

During all the last years of his life, his work was only made possible by her support. Her knowledge of symptomatology was said to be marvellous. It is fitting that Hahnemann's disciples have given such cordial welcome to women in medicine since the master's work was begun, and his greatest success accomplished by woman's aid.

Thirty medical women made themselves eminent in the eighteenth century. Madame Breton perfected a system of artificial nourishment for babes. She procured a patent for the same, and thereafter none but children of the rich could realize any benefit from the invention. Elizabeth Blackwell, born in England in 1712, published a medical botany in 1736, which was the first of its kind in any country. Madame Ducoudry, of France, was the first lecturer who used a manikin, which she invented and perfected. It was approved by the French Academy of Surgeons December 1, 1758. In 1766 she delivered, by special request, a series of lectures before the Naval Medical School at Rochefort. Donna Morandi, born 1716, was the inventor and perfecter of anatomical preparations in wax. Her excellent work won the admiration of the college, and in 1758 she was made professor of anatomy. Mademoiselle Biheron began her anatomical studies at the age of sixteen years. From her girlish earnings she paid persons who stole and brought to her bodies, which she concealed in her chamber. She conquered the difficulties of the knife, but could not preserve the cadaver long enough to satisfy her curi-

osity. For this reason she imitated the parts in wax for further study. Her wax work was open to the public on every Wednesday, was crowded by visitors, and was finally purchased by Catharine II. of Russia. Elizabeth Nihell, born in London, in 1723, made herself memorable in England. Sarah Stone was the author of a work called *Complete Practice*, published in 1737. These two women resisted quackeries, which deluded all the faculty of their time. Madame La Chapelle, born 1761, received the degree of M.D. Her lectures were distinguished for clearness, force, and beauty. Madame Wittembach, born at Haineau, in 1773, was distinguished for her knowledge of Greek, and took the two degrees of A.M. and M.D. from the college at Marburg in 1827. Mrs. Dunally, an Irish midwife, made herself remarkable by performing the Cæsarean operation with success after twenty-four physicians of the century had failed. She operated with a razor, and held the wound two hours with her lips waiting a surgeon's arrival. Lady Mary Wortley Montague rendered the greatest service to medicine and the world by effecting the introduction of inoculation in 1721, seventy-eight years prior to Jenner's service. Madame Rondet, born 1800, is remarkable for having perfected a tube for the restoration of babes born asphyxiated. Madame Boivin is well known for her splendid professional success. She published books on accouchments, hæmorrhages, tumors, etc., in 1812, 1819, 1827, and 1828. Dr. Heidenreich, a baroness, died in July, 1859. Her father founded the famous hospital at Berlin. She studied in the universities of Göttingen and Geissen. She then took up her abode at Darmstadt. She was indefatigable in her devotion to obstetrics, and universally honored as one of its first authorities.

As we come nearer our own era, we find that first of American women, Dr. Harriet K. Hunt, after years of careful study and frequent applications for admission to medical schools, but as often rejected, began practicing medicine in 1835, but did not receive her diploma until after Dr. Blackwell, who has been recognized as the first doctor-woman of our time. Dr. Hunt's life was a worthy example. At her death she left a fund for the Boston University, to benefit other women seeking medical knowledge. Martha J. Flanders, of Boston, still living, first filled the position of president of a county society.

Dr. Hunt and those rapidly following her labored with patience, sobriety, and tenderness, which made their mission acceptable where it was not desired, and desired where it was first hardly endured.

She began in 1835. The numbers increased until the census of 1860 reported 80; the next decade reported 250; and at the last numbering we are assured that 3200 women have legal authority to practice the healing art in America. These are distributed from Maine to Mexico, from Florida to Alaska. Some have published books; several are college professors; many are at the head of institutions, asylums, or hospitals; a few have become surgeons; more are busy with general practice; and a host may be found ministering to their own sex.

We will not deny that some, like a greater number of men, have lived, labored, and died without being known or remembered beyond the limited circle they served. Not every one can be a Grace Roberts or a Julia Holmes Smith, an Adaline Church or an Emily Pardee, but many others are equally eminent in the locality they bless.

Drs. Merrill and Baldwin, now in India, graduates of the Homœopathic Department of the University of Michigan, are types of the doctor-women who serve humanity in the benighted lands. Not alone in foreign fields are women physicians doing missionary work, but in every city may be found one or more guiding the wayward daughter, leading back the erring wife, or restraining her who would commit evil deeds.

The history of the details and extent of this work is only written by the "recording angel," and will be made known when His books are opened. This work is often made possible because of the influence of homœopathic medicine on the mind and disposition. Stramonium, hyoseyamus, anacardium, bryonia, nux vomica, platina, belladonna, sulphur, and veratrum, wisely selected and administered, improve the character equally with the powerful sermons of a Spurgeon or a Talmage.

Brethren, *we* enter medicine *not* as a disturbing influence, as monsters, or those out of place, but in the line of human duty, an element in relieving pain, an aid in education, an influence for reform. Believing it is not necessary to part with the gentler graces of womanhood when we aspire to the ability and acquisitions of doctors, rather we come with a trust in the Infinite Father who protects the beauty and truth of the moral nature, making unstinted effort to be suited to the duties and prepared for the sacrifices.

A RADICAL CURE FOR RETRO-DISPLACEMENTS OF THE UTERUS.

BY F. F. LEHMAN, M.D.

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(Read before the Homœopathic Medical Society of the State of New York, February 9, 1892.)

THE purpose of this report is to bring before the profession a method of procedure which has proved to be a radical cure for retro-displacements of the uterus. This result may be obtained by either Wylie's or Alexander's operation. They are both valuable, but for different conditions; and when one is called for, the other is contra-indicated. Alexander's operation is only useful when there are no firm adhesions, nor any disease of the appendages sufficiently grave to make it necessary to open the abdominal cavity. However, the majority of cases are not of this class. As a rule, when there are serious symptoms associated with retro-displacements, there is some disease of the ovaries or tubes, or both, which will not yield to other than surgical treatment. It is in this class of cases that Wylie's operation is indicated. I am aware that Skene and others would first liberate the uterus, then follow Tait's operation with that of Alexander; but this subjects the patient to unnecessary risk and mutilation. We cannot ignore the great importance of restoring retro-displacements at the time diseased appendages are removed. It makes but little difference how badly diseased the tubes and ovaries may be, the immediate results of Tait's operation will not be entirely satisfactory unless all backward displacements are corrected. It is true, that if one will have the patience to wait for atrophic changes to take place, the patient will finally regain her health; but this takes from six to eighteen months, and it is very difficult to make them understand that in time they will be cured.

During the last year it has been Dr. Lee's practice to correct, by Wylie's method, every retro-displacement of the uterus at the time diseased tubes and ovaries have been removed. There has not been a single instance in which the relief was not prompt and apparently permanent.

As Wylie's method is comparatively new to the profession, I take this opportunity to report its results in several cases that have been under treatment in this hospital.

First, a few words on the technique of the operation:

The patient is as carefully prepared as for any other form of ab-

dominal section. The bowels are evacuated by a purgative dose of *oleum ricini*. The genitalia and abdomen are shaved and thoroughly scrubbed. On the morning of the operation a hot douche is given, and throughout the strictest asepsis is observed. No sponges are used save a known number made of absorbent cotton wrapped in gauze. The wound is kept dry by dossils of cotton wrung from hot water, and these once soiled are thrown away. All adhesions are broken up, or ligated and divided. The appendages, if diseased, are removed, and the fundus uteri brought forward into its normal position. Each round ligament is secured and folded upon itself by grasping it in the centre of its length with a pair of forceps, and elevated out of the wound as much as possible. Two or three silk ligatures, according to the laxity of the ligament, are passed first through the centre of one side of the fold, then through the centre of the other side, and tied. This cuts off the circulation from but one-half of each side of the fold, while between the ligatures it is not materially interfered with.

In this way the round ligaments are sometimes shortened two or three inches. The silk becomes encysted and gives no trouble by its presence; while, at the same time, it strengthens the adhesions which take place between contiguous surfaces of the folded ligaments.

The following cases taken from the hospital records are given in illustration of the above outlined method of procedure:

CASE 1.—Mrs. D., æt. 39, housewife, has had seven children. There is a very decided history of tuberculosis in both branches of the family. In early life the patient was thought to be going into consumption, but after marriage, at the age of seventeen, her health improved until the birth of her first child. Since that time she has never been free from tearing and darting pains in the back, base of brain, and legs. About four years ago the right ovary was removed. This afforded relief from the pain in the right inguinal region and the right leg, but not from the backache or headache. One year after the abdominal section her youngest child was born, and since then she has grown steadily worse. There is a constant foetid, vaginal discharge. Examination, October 1, 1891, revealed a ventral hernia, which is a sequel of the abdominal section. The uterus was enlarged, prolapsed and retro-flexed.

Operation October 2d. The hernial sack was dissected out, the left tube and ovary removed, and the uterus brought up and forward and held in place by shortening the round ligaments.

The patient made a good recovery, unattended by complications. While in the hospital she did not experience any of the pains from which she suffered on admittance. The headache, backache, pelvic tenderness, and pain in the right side and leg, have all ceased. She left the institution November 31st feeling remarkably comfortable.

CASE 2.—Mrs. K., æt. 57, housewife; has borne one child. At the age of 21 the patient suffered from some acute disease, the nature of which is not definitely known. After her recovery she did not menstruate for six months; and when the flow was re-established it was attended by severe pain, which was relieved by hot applications. During the intervals she suffered from constant pain in the back, heat, and tenderness in the pelvis and abdomen, headache and insomnia; she was also very nervous, weak, and hypochondriacal. September 30th an examination showed the uterus retro-flexed, and, at the point of flexion, the tissues were atrophied to the thickness of card-board.

On October 1st the diseased ovaries were removed, and the uterus held in place by shortening the round ligaments as above described. The result was all that could be desired. The temperature chart showed no deviation from the normal, save on the fourth and fifth days, when 100.5° was registered. She was discharged October 29th. A letter of inquiry, sent the latter part of November, was answered thus:

"I am now free from all my former pains, and am improving every day. I am looking forward with great pleasure to years of health and comfort."

CASE 3.—Mrs. C., housewife; has had two children. Pain in left groin whenever fatigued; backache, though not severe. Her troublesome symptoms were mostly confined to the head. She constantly experienced a "gone and dazed sensation." She was nervous, irritable and down-spirited; so much so, that her naturally bright and vivacious disposition was said to have changed to an alarming degree within the past year. An examination, under chloroform, revealed a tumor of the left ovary, and a retro-flexion of the uterus. The tumor proved to be a dermoid cyst, and was removed. The uterus was then brought forward and held in place by shortening the round ligaments, according to Wylie's method. No shock followed the operation, and the patient rapidly recovered her former buoyancy of spirit.

She was also free from a feeling of weight about the hips; and the whole body was described as "much lighter." Her head became clearer, and she left the hospital, December 1st, well.

CASE 4.—Miss M., æt. 40. Occupation, none. In early womanhood she became a mother *ex legibus*. At this time she probably contracted syphilis, which played sad havoc with her eyes, and set up a choroiditis, from which she nearly lost her sight. On admission to the hospital her chief complaints were great pain in the back and sides, with obstinate constipation. Her nervous condition was pitiable. She was wholly unable to carry on ordinary conversation.

October 26th, the abdomen was opened, the diseased ovarian tubes removed, and Wylie's operation performed to correct the retro-flexion.

A few days ago, I received a letter from her, in which she stated that she was free from all the old aches and pains. Her general health is much improved, and both the patient and her friends seem very exultant over the success of the treatment.

CASE 5.—Mrs. M., æt. 52, dressmaker; has had two children, and passed the menopause at 50. November 7th, was admitted to the hospital. She complained of constant pain in the back and sides, which was often aggravated by paroxysms of more severe pain. After eating, she felt as if there was no room for "food or breath." Examination showed a retro-flexion, which was corrected by Wylie's method of operating. Her recovery was tedious and prolonged, owing to the development of two deep stitch-abscesses in the very thick abdominal walls. She was, however, relieved of all her former pains.

A CASE OF SEVERE SCALD WITH EXTENSIVE DESTRUCTION OF THE SKIN.—GRAFTING OF FROG'S SKIN—RECOVERY.

BY RALPH ST. J. PERRY, M.D., SHENANDOAH, IOWA.

On the morning of July 30, 1890, I was called to attend Charles W. Kellar, an employé of the Indianapolis Veneer Company, who had fallen into one of the large vats in which logs are steamed and softened before being set in the veneer cutters. In falling he had struck upon some logs floating in the vat, and was thus prevented from immediately sinking to the bottom, some ten or fifteen feet; this trifling delay gave his fellow-workmen time to rescue him. The time he was in the vat did not exceed two minutes.

Upon reaching the man about an hour after the accident, I found that from the ensiform cartilage down he was badly scalded, huge blisters having formed all over the injured portion of the body, also on the left arm near the shoulder. Large pieces of skin had come away in removing his clothing, and the hair on the limbs had come

off in patches just as it does from a scalded hog. The penis and scrotum were swelled so enormously as to lose all resemblance to the natural organs. Dr. L. W. Jordan (ocular surgeon), who had first seen the case, had applied the aqueous solution of calendula to the surface, but upon his turning the case over to me on my arrival, a mixture of lime water and linseed oil (carron oil) was applied. At this time the pulse was 80 and the temperature 97° ; no pain was felt, nor had there been any since the injury; the man seemed perfectly rational. (He subsequently told me that at no time before the evening of the first day did he suffer any pain; he "hollered" because he could, and thought it was what he ought to do in such a case.) When seen again in the afternoon the pulse was 150 and the temperature 97.2° ; some considerable pain was now felt, and the man seemed dull and listless. During my absence at noon he had eaten a piece of mince pie and drank a cup of coffee. Aconite 3x and arsenicum 3x were given every half hour alternately, one-quarter of a grain of morphia sulph. with atropia sulph., one two-hundredth of a grain, was administered hypodermatically to allay pain and put a stop to the restlessness which had now become much aggravated. Teaspoonful doses of cognac were given every hour to stimulate. The bowels had moved prior to the accident, and there was no difficulty in urinating. Patient slept some.

July 31st.—Morning pulse 150, temperature 97° ; no signs of reaction; brandy and arsenicum continued and aconite stopped. At noon I was hastily summoned, and found the patient suffering from dyspnoea and a severe acute cedema of the mucous membrane of the throat, which threatened suffocation. All medicines were immediately suspended and apis 3x given every fifteen minutes. Preparations were made for tracheotomy, if necessary, as a *dernier ressort*; but the apis proved amply able to cope with its *similimum*, and the danger was bridged over. Later, the cognac was resumed. The patient several times during the day urinated freely and the bowels moved. Evening pulse 150, temperature 97° , the same as in the morning.

August 1st.—Morning pulse 120, temperature 98.2° ; reaction setting in; brandy stopped; throat much better; apis reduced to once every half hour. To-day pus appeared in spots, demanding a renewal of the bandages, which had not been changed since the first day. This was, naturally, a very painful procedure, and as the general condition of the patient precluded the use of ether or chloroform, and the extent of the injury made the use of cocaine or other local anæsthetics dangerous because of possible toxic effects, the operation had to be performed the best way possible without anæsthesia. With

scalpel and scissors, as tenderly as could be, the dressings were cut off, frequently taking with them huge pieces of disintegrated skin, and, after three hours of tiresome work, the patient lay in fresh cotton and linen, with an iodoformed petroleum ointment applied to the raw surface. Bowels moved at 5 A.M., and again at 7 P.M.; urinated without difficulty. A severe attack of singultus came on during the day, which bothered him very much. Small pieces of ice were given him to suck, which soon moderated the attack, and eventually stopped it. Reaction having set in, and there being now some hopes of recovery, the diet was looked to. When milk was proposed the patient revolted and positively refused to take it, saying he had not tasted milk for over twenty-five years, and that he would not begin now. Eventually he capitulated, and teaspoonful "doses" were given every half hour. Evening pulse 120, temperature 99°.

August 2d.—Morning pulse 115, temperature 100°. The nurse reported considerable diarrhœa during the night and early morning; milk stopped for four hours during the morning, and then renewed as a mixture of milk and eggs. Singultus reappeared during the morning together with restlessness; ice given to suck; iced cloths applied to abdomen, and four doses of *ignatia* 3x given. Throat much better and *apis* reduced to once every hour. During the day about twelve ounces of the milk and egg mixture were taken, the bowels moved only once, and urine was passed five times. Patient slept three hours during the day. Evening pulse 118, temperature 101.1°.

August 3d.—Morning pulse 108, temperature 100°. Dressings changed during the morning. Patient seemed unusually thirsty and drank considerable water. Gave some solid food, also gave a prepared food known as "malted milk." Bowels moved normally and urine passed several times. Several hours' sleep during the day. Evening pulse 120, temperature 101.3°. *Apis* continued every hour.

August 4th.—Morning pulse 110, temperature 100.5°. Patient stood change of dressing very well. Ate two eggs, soft-boiled, during the morning, and had two involuntary movements from the bowels. During the afternoon ate an egg and took some malted milk mixture. Throat so much better, and all danger of recurrence being apparently passed, the *apis* was stopped and *arsenicum* 3x given every hour. Thirst has disappeared. Late in the day an oily diarrhœa came on, but only lasted a few hours. Evening pulse 120, temperature 101.8°.

August 5th.—Morning pulse 118, temperature 99.4°. Bowels

moved twice. In changing the dressings it was noticed that much of the skin, which it was hoped had not been entirely destroyed, was undergoing decomposition and that pockets of pus were forming under it. Large sheets of this skin were dissected away from the underlying tissues, an operation requiring much delicate manipulation, and four hours' time. There was noticed in the discharges considerable "blue pus" which examined microscopically showed the bacteria as pictured by Koch in his micro-photographs. The patient ate some wine jelly and vegetable soup. Arsenicum continued. Evening pulse 120, temperature 100.6°.

August 6th.—Morning pulse 120, temperature 100°. Bowels and urine all right. In changing dressings the dead skin from the thighs, chest, and back was removed. Patient ate chicken and is gaining in strength. Evening pulse 126, temperature 101.4°.

August 7th.—Morning pulse 112, temperature 100.2°. "Dressed and skinned." Bowels and urine all right. Good appetite to-day, ate eggs, three baked apples, toast, and took some milk and egg-mixture. Evening pulse 120, temperature 101.8°.

August 8th.—Morning pulse 108, temperature 99.8°. In changing dressing this morning, the skin was dissected away from the scrotum, penis, and abdomen, opening up several large pus pockets in the scrotum and in each groin; the hair on the mons was clipped about as short as could be with scissors, curved on the flat. Ate eggs and toast with considerable water. Bowels moved once. Evening pulse 126, temperature 102.8°. Alternated aconite 3x, with the arsenicum every other hour.

August 9th.—Morning pulse 104, temperature 99.2°. Aconite stopped during the morning. Changed dressings and skinned calves and feet. Bowels and urine O. K. Ate beef, eggs, toast, and a small piece of watermelon. Evening pulse 116, temperature 102.8°. Aconite 3x, given as on the evening previous.

August 10th.—Morning pulse 98, temperature 99.2°. Stopped aconite. Patient ate banana at midnight, and toast and eggs during the day. Dressings changed, and fragments of dead skin removed. Some malarial symptoms coming up, china ars. 3x, was given in the evening in place of the plain arsenicum. Evening pulse 106, temperature 100.2°.

August 11th.—Morning pulse 106, temperature 99.2°. Patient slept well during the night, and seemed much refreshed thereby. Dressings changed. Bowels and urine O. K. Ate watermelon, eggs, and beefsteak. Evening pulse 112, temperature 101.3°. China ars. continued.

August 12th.—Morning pulse 116, temperature 98.6°. China ars. continued, and in the evening silica 3x ordered given once every four hours. Good appetite, ate bread, chicken, banana, raw onion, tea, and coffee. Evening pulse 116, temperature 102.8°.

From this date on to the termination of the case, the patient became most emphatically omnivorous in his diet, eating everything within reach, with an *abandon* that shocked some of the more conservative members of the family; his bowels and kidneys operated regularly and without trouble of any kind; the one remedy used was silica 3x with only a sporadic dose of aconite to overcome some occasional feverish tendency. Once the nurse gave a dose of coffea 12x for restlessness, but other than that he needed no medicine to help him rest at night. His pulse and temperature during this period ran as follows:

Date.	Pulse.		Temperature.	
	A.M.	P.M.	A.M.	P.M.
August 13th, . . .	108	104	98.4°	102.5°
" 14th, . . .	108	118	99.8°	102°
" 15th, . . .	104	122	99°	102.5°
" 16th, . . .	104	112	99.2°	101.8°
" 17th, . . .	104	120	100°	102°
" 18th, . . .	94	118	98.5°	101.5°
" 19th, . . .	—	98	—	100.4°
" 20th, . . .	90	100	100.2°	100.2°
" 21st, . . .	98	98	98.8°	100.4°
" 22d, . . .	—	92	—	98.4°
" 23d, . . .	—	100	—	99.8°

After the case had progressed far enough to show that the patient could recover if properly treated, the question arose, what is to be done to supply the man with skin? The history of previous cases of extensive burns had proven that as long as the ulcerated surface remained open, and excretion and absorption were carried on, there was no immediate danger of death if the strength and general health kept up, but just as soon as the surface began to heal over, and the open surface gave way to an impervious cicatricial one, then danger became imminent because of suppression of secretions and an overburdening of the kidneys and lungs. To obviate this difficulty something must be done, and that something must take the place of the normal cuticle to such an extent as to prevent any material suppression of its secretory functions. Naturally the first operation suggesting itself, was skin grafting, but an investigation showed a most disparaging lack of persons who were willing to sacrifice any portion of their own skin, to supply the necessary foundation for the

procedure. In the midst of this dilemma my father (Joseph R. Perry, editor of the *Indiana Pharmacist*), called my attention to a paragraph, then going the rounds of the medical journals of this country, giving an account of an attempt at grafting frog's skin on a case of chronic ulcer of the leg. Immediately the idea suggested itself to me, why not try frog's skin on the patient? and no sooner thought than preparations were made for the attempt. After some two or three days, a supply of frogs was secured from the swamps near South Bend in northern Indiana. August 18th, with my father as assistant, the first operation was made; the ulcerated surface was thoroughly cleansed with sublimate solution and hydrogen peroxide, and rendered as nearly aseptic as possible. The frog was thoroughly scrubbed with hydronaphthal soap in hot water, and rinsed off in sublimate solution $\frac{1}{4000}$; with a pair of sharp scissors the spinal cord was snipped in twain at the base of the skull and the pearly-white abdominal skin loosened up and torn from the body. This skin was then transferred to a basin of warm $\frac{1}{4000}$ sublimate solution and then cut up into minute pieces about one-eighth inch square. Everything being now ready the field of operation was again cleansed, and the grafts laid upon it with the visceral side of the skin in apposition with the granulations. Having fairly covered the surface with the grafts, it was lightly dusted over with iodoform and bound up with moist calendulated gauze, and the whole bandaged with an ordinary roller. On the third day the dressings were removed, and much to the pleasure of the patient and his attending surgeon, it was seen that many of the grafts had taken root. Those unattached were removed, the surface cleansed and calendula dressings reapplied. Of these operations forty-two were made in various parts of the denuded area, and of these, ten were regarded as successful; as this proportion is a very good percentage of the whole number of attempts, the entire procedure was accepted as a success. The first grafts were made on the anterior aspect of the ankle-joint, there being a deep ulceration there, and it was feared that any resulting cicatrix would cause a partial ankylosis; subsequently the popliteal space and Scarpa's triangle were grafted, and the results in all cases far exceeded our most sanguine expectations. September 5th, the man had so far recovered as to render further attention unnecessary, and on September 19th, he called at my office, having walked three squares from the street cars. About November 1st, he returned to work in his old position, and now one year afterwards, tells me he feels as good as ever. His legs are unusually sensitive to heat and cold, and occasionally he says he feels a

little stiff. For some time there was much fear that the reproductive powers would be ruined because of the injuries, but some weeks after being able to be about, this fear suddenly disappeared,—probably because of reasons best known to the patient. Soon after the grafts became attached and took on the functions of foci of skin development, it was noticed that the newly-formed cuticle was of a deep bluish-red color, but this has gradually faded away until now the color is almost that of the natural healthy skin, the man possessing the appearance shown in the accompanying illustrations.



As to my prognosis in this case, when first called I stated that it was almost impossible for him to live, but that if he survived the shock and lived three days, his chances for the next two weeks were fair; if he lived two weeks without any complications setting in in his internal organs, his chances for recovery were good; and that if he recovered from the injury he could expect to live for twenty-five years longer, his age at that time being thirty years.

A MODIFICATION IN THE TECHNIQUE OF OPERATIONS FOR THE REPAIR OF COMPLETE PERINEAL LACERATIONS.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

MY experience has been, and I think I reiterate that of most operators, that the principal cause of failure after plastic operations to restore the perineal body when the sphincters and the rectum are torn, is infection through the wound sutures in the gut. If this element of danger could be *positively* eliminated, the operation would be reduced to the correction of an incomplete tear, plus finding and uniting the ends of the sphincters. This danger was impressed upon me very forcibly by a partial failure, a case in which the ends of the sphincter united, but a leak appeared above, producing a sinus which opened on the external surface of the perinæum. Fæcal leakage persisted for a long time, and the integrity of the perineal body was considerably impaired.

With this case fresh in my mind, I was called upon about a year ago to repair a very bad tear, the worst one I have ever met with, which completely destroyed the perineal body, extended up the vagina, almost reaching the cervix, with prolapse of the rectal mucosa at a point well up, and went through both the rectal sphincters and about two inches of the bowel. There was such incontinence of fæces that the patient was unable to walk about without soiling herself, and with this was associated a complete prolapse of the uterus. Remembering the ease with which the rectal mucous membrane can be drawn down after resecting "the pile-bearing inch" in Pratt's operation, it occurred to me that I could use this as a septum to *positively* shut off any wound infection from the bowel side. The rectal mucous membrane was accordingly loosened by an incision with scissors along the triangle running up the bowel, its edges seized with T-forceps, easily drawn down and held well over the anus by the mere weight of the instruments. There remained then but the ordinary operation for a complete tear *minus* the stitches tied into the rectum. The edges of the rectal triangle were freshened and united by buried sutures of catgut; the torn ends of the sphincter were exposed and brought together in like manner; the oblique cicatrix was dissected out and the gap sutured (posterior colporrhaphy), and a new perineal body formed by the flap-splitting method. Of course, the two halves of the flap had to be united in the centre within the vagina.

The perineoraphy completed, the T-forceps were removed, and the drawn-down rectal mucous membrane was allowed to retract and stitched to the anterior or *new* half of the anus. The result has been perfectly satisfactory; the uterus is supported; there is a good, firm perinæum, and the sphincter is completely restored.

I have since had two opportunities of testing this operation with very satisfactory results.

PUERPERAL SEPTICÆMIA.

BY G. MAXWELL CHRISTINE, A.M., M.D., PHILADELPHIA.

PUERPERAL septicæmia is morbid action set up in the puerperal woman by the introduction into her system, through the generative organs, mostly, of septic matter.

The word septicæmia implies a belief in the power of putrefactive or putrifying matter, when entered into the lymphatic or venous current, to create certain diseased conditions, characterized by a degeneration of the tissues which, if not checked, tends to progress to the death of the individual. Puerperal septicæmia is distinct from ordinary surgical septicæmia only in the fact of its occurring in the puerperal woman, the puerperal condition opening the door to an introduction of septic matter; while, in the instance of surgical septicæmia, the introduction of the septic material is through a wound irrespective of puerperal condition.

Puerperal septicæmia is to be studied only in relation to the puerperium, and is, therefore, in its ætiology, symptomatology, course, and treatment, peculiarly within the domain of the accoucheur, and not of the surgeon. Not every instance of infection of the puerperal woman ends in septicæmia. The virulence of septic vaginitis or metritis, and even peritonitis, may extend no farther than the affected organ, and there may be no passing of the infection or other pyogenic materials into the lymphatics or veins of the general system, but the whole force of the attack will be expended on these organs, without systemic changes such as take place in septicæmia. Hence, it is well, in studying puerperal infectious diseases, to classify them under the heading which relates to the cause of the disease, the organ diseased, and, being in a puerperal woman, to the puerpery.

Effort has been diligently made of late years to eradicate from the popular mind the use of the term puerperal fever, and to substitute for it a term or terms of a more definite character. Success has been nearly attained in this matter; and though, in many respects, the term *puerperal fever* is satisfactory and significant, the term puerperal septicæmia better defines the cause, and serves to keep this cause before the attention of the practitioner, while, at the same time, it excludes many other non-septicæmic puerperal disturbances and pyrexias, and relegates them to their proper class. Certain it is, that since a parallelism has been established between ordinary surgical septic fever and puerperal fever, the latter disease has become less common and the effect of treatment more certain.

Advocates of the theory that puerperal fever is but "fever" peculiar to the puerpery, but having no relation of effect to a disease-germ as a cause, endeavor to uphold their faith and still believe the disease not to be consequential to local lesions, but that its symptoms are essential, that it is a zymotic-fever disease, that the cause may be epidemic, contagious, infectious, or malarial in character, and that septicæmia may exist, with or without puerperal fever. (Barker.) The mass of attainable clinical facts would seem to be sufficient to disenchant those entertaining such a theory, but medical truths often find difficulty in setting aside settled opinions, though these latter be manifestly wrong. The light which science sheds is often dimmed in the darkness of settled and obstinate conviction, and sometimes, too, fails in its purpose because not itself perfected. Puerperal fever is generally accepted to be septicæmic and in common with surgical septicæmia, and is so maintained in this paper, but medical science and medical art have yet to win many medical minds over to this view; and, on the contrary, this view may be supplanted by another not yet conceived.

Just, as formerly, peritonitis was a term applied to nearly every variety of pelvic inflammation, and even now is so applied by the ill-informed, the term puerperal fever was made to include all fevers attacking the puerperal woman, not manifestly those of small-pox, pneumonia, etc. Puerperal fever should be limited to a fever produced by septic causes, whether heterogenetic or autogenetic, and thus be made synonymous with puerperal septicæmia and pyæmia. It is inconceivable, from the standpoint of the present status of medical science, that the puerperal woman should be made subject to a fever process having special reference to her generative organs without that process finding its cause in the introduction into the system,

through the generative tract especially, of some poison-germ from without. The explanation of Hippocrates, that the lochia, when suppressed, furnishes the cause of puerperal fever, or, that other explanation, that the milk wandered from the breast and settling at various points in the body provoked a fever process at those places, is irrational.

Surgical septicæmia is caused by infection through a wound, as by injury or the knife; puerperal septicæmia by infection through denuded or lacerated perineal, vulvar, vaginal or uterine tissues, during childbirth, or through the open channels at the uterine placental site, or, possibly, through some other inception point in the body. This infectious principle is believed to be bacterial. In 1847, Semmelweis first pointed out the similarity of puerperal fever to ordinary septicæmia and pyæmia. Koch developed our knowledge of this similarity into a certainty, by his bacterial researches, in which he established a relation between the disease and special bacteriæ. The entire absence of these bacteriæ in the healthy tissue, and their invariable presence in the diseased tissue, greatly advanced our information concerning the ætiology of puerperal fever, as well as of certain other diseases. Putrefaction and suppuration are proved to be due to micro-organisms, and cannot be produced without their presence as the original cause. To those who are willing to be convinced, there is no other conclusion than this from the mass of accumulated and accumulating bacteriological and clinical evidence. Antisepsis and asepsis have accomplished such results that, as an instance, surgeons will guarantee a thorough healing in the lines of incision in a laparotomy within six days after operation, if the latter is done under thorough protection from sepsis. Such a wound, examined at any part of its course, will be found entirely free from pathogenic organisms; but, should suppuration occur, these organisms in one or another form can, in every instance, readily be found present. These organisms are capable of reproducing the same conditions of suppuration, etc., when introduced into healthy tissue, but it is yet to be demonstrated, satisfactorily, that any substance free from these organisms can produce such a morbid alteration of the animal tissue.

These points settled, that infection is the only cause of the class of cases called septicæmic or pyæmic, we now are ready to define septicæmia and pyæmia. The *Century Dictionary* gives the best definitions we know of these diseases, and we copy them from that magnificent work.

Septicæmia (given under definition of sepsis) "contamination of the organism from ill-conditioned wounds, from abscesses, or certain other local ptomaine-factories, or bacterial seminaries." Pyæmia is "a febrile disease caused by the absorption of pus, or certain of its constituents, or of its bacteria, with the formation of metastatic abscesses."

That which is understood of these two diseases, ætiologically, must be understood of puerperal septicæmia and pyæmia, since the uterus, just emptied of foetus and placenta, is to every intent and purpose an open wound into which infection can enter and produce conditions identical with surgical septicæmia and pyæmia.

The identity of puerperal sepsis with surgical sepsis is all important. It does away with what we regard as the baseless theories of the causation of puerperal fever, and among which accoucheurs have heretofore floundered as in a rudderless boat at sea; furnishes accoucheurs with a definite, rational and satisfactory ætiology whereon they shall construct prophylaxis for the puerperal woman; and presents them with a more substantial basis for their therapy; clarifies the atmosphere in which the puerperal woman lives; and adds to her well-being by placing within the knowledge of her attendant the means by which to protect her from a poison heretofore finding little and often no hindrance to its introduction into her system. It relegates to their proper spheres the various mal-conditions to which the puerperal woman is susceptible, and thus contributes to their proper understanding and treatment.

Since the germ-theory has come with its suggestion as to the prevention and the treatment of what are now specified as septic diseases, the surgeon's knife has gone deeper and deeper into the human frame, and the healing of the wounds his knife has made no longer serve as nightmares to awaken him in his dreams of success. Thorough protection from the introduction of disease-germs, makes him certain beyond peradventure of a reunion of tissue-continuity.

None the less has the germ-theory come to the help of the accoucheur, and he now bids defiance to puerperal fever if he be allowed the weapons perfect antisepsis and asepsis offer him, or he so much seeks.

This revelation of theory and practice in the cure of the puerperal woman has come upon us so speedily that those who have been wedded to the old and many-sided theories concerning puerperal fever, have not had time to shake off the dust from their garments,

extract the mote from their eyes, or sweep the cobweb from off their intellect.

The poison of puerperal septicæmia is conveyed from some similar cause just as it is conveyed to a person suffering from surgical or ordinary septicæmia. In the one instance, the micro-organism finds entrance through the open, denuded or torn, genital tract of the puerpera, and in the other through an open but non-puerperal wound. That there may be varieties of this organism, producing possibly different types and qualities of disease, is true, and is found equally so in the puerperal condition as in the surgical. The virulence of the poison, the quantity absorbed, the location, extent and receptivity of the wounds or open channels, and the degree of the system's yielding to the germ, are all determining factors in the resultant pathological change, whether in the puerperal or the surgical case.

In studying puerperal septicæmia or pyæmia we have to consider, as leading up to it, many processes not entitled to be regarded under that term, but which are best termed local infections, but which nevertheless it is important should be studied and understood. Between the true septicæmia or pyæmia and these other conditions there is no well-marked line of demarcation, except it be indicated by systemic pyrexia, for they are all results of germs finding introduction through identical channels. It is conceivable that germs of weak powers should expend their force on a part of the vagina or uterus, and causing only local inflammation; that others of more potent power should enter deeper into the tissues, causing more acute, longer lasting and more destructive, but, even yet, only local changes; and that others having greater intensity of virulence should enter the system of the individual through the vaginal or uterine lymphatics or veins, and work out their process of development throughout the system, thus creating a systemic disease as contrasted with those changes referred to as local and non-systemic.

Thus we must draw a line between local infectious disease and general infection or septicæmia, which line I am inclined to believe is marked by the presence or absence of chill and fever. The former I would not include in the term puerperal fever; the latter comprehends puerperal fever, and puerperal fever comprehends it.

It is believed, and on this belief rests much of the validity of the germ-theory, that the vagina and uterus of the pregnant and of the lying-in woman have in them naturally nothing which can possibly produce inflammation or fever, and that if inflammation takes place,

it is entirely due to the introduction of pathogenic germs from without. Large wounds have taken place in the integument and tissues of these parts and by reason of the absence of pathogenic organisms, or, if present, by reason of the non-susceptibility of the part to their influence, healing has taken place without inflammatory or septic manifestation. From the present standpoint of medical science, such an inflammatory or septic manifestation is consequent, not on the rudeness or violence to which the part is subjected, but to the introduction from without of a poison, bacterial or microbic in character.

The puerperal woman is in as susceptible a condition to these outer pathogenic poisons as though she had been the subject of a laparotomy for oöphorectomy, or hysterectomy, presenting for their introduction essentially an open wound in a part lately subjected to an equivalent of the roughest usage, and with the lymph and venous channels in the highest possible state of receptivity. Thus, whilst she may resist disease at other periods in her life, her state has become altered, her power of resistance diminished and her susceptibility increased. Her blood is in a condition better fit for the lodgment and development of germs; and her whole organism has seemed to have undergone a condition preparatory to the reception of the bacilli family and other disease-causes. The fact that this change in her circulatory and other tissues has been for another purpose, does not affect this fact. Conditions of mind and body most favorable to these changes, are typically found in the average, if not in every lying-in woman.

The poison producing the disease treated in this paper, is transmitted through one or more of many possible media from some disease forms in another individual. Clothing, instruments, cloths, sponges, the air, and the person of the attendant, are the most common of these media. Suppurating, putrefying, septicæmic and pyæmic tissues are causes. The infecting contagion carries the disease from the diseased individual to the one to be infected.

Evidence is abundant that suppuration furnishes a cause for puerperal infection. Suppurating centres on the person of the accoucheur and attendant have been most prolific causes. So have been patients of the accoucheur who have had cancers, carbuncles, etc. Students have carried infection from the dissecting-room, the dead-house, filthy habitats, from pest-hospitals, and from the street, into the lying-in chamber, and the patient has become therewith infected.

The lying-in woman having been made susceptible to infection

by the act of child-birth, the most opportune time for the reception of the poison is during or shortly following the labor. Repair of the injured parts sets in at this time, and in proportion, as healing takes place, does the liability to infection diminish. The poison may have found lodgment in the parts of the woman a long time before delivery, remaining dormant because of there being no open or willing channels to serve as carriers, until the act of labor opens the way to ingress.

Of the local genital and pelvic infections, we have them occurring in the vulva, the vagina, the uterus, the tubes, the ovaries, the pelvic cellular tissues and lymphatics, the inguinal lymphatics, and the peritonæum. Some of the more distant organs affected are the lungs, the heart, kidneys, liver, spleen, the meninges, the disease reaching these parts through the veins, the result of a uterine phlebitis. Indeed, no tissue or organ is exempt from the infection, so long as there is a direct or even indirect channel between it and the entrance point of the infection.

The symptoms of these several infected parts vary according to the seat of the infection, the character, kind, and the virulence of the infection. Occasionally, the inflammatory or other change passes through its various phases in a mild manner, in which case its presence may hardly be suspected. This is true, often, of ulcerative vulvitis or vaginitis. In others, severe chill, high fever, and the gravest systemic manifestations quickly arise, and may pass soon to a fatal issue.

In locating the cause of any disturbance in the normal condition of a puerperal woman, we should begin at the vulva and examine inward until the cause of the trouble is discovered. The vulva should be carefully scrutinized for ulcers, points of inflammation, swellings, redness, diphtheritic patches, etc. The vagina should similarly be investigated. The uterus, with respect to the cervix, its endometrium and body, should be carefully examined and evidence secured, if it exists, of the various forms of inflammatory condition possible in this organ.

The tubes and ovaries and the whole pelvic cavity should be carefully explored for infected centres,—salpingitis, oöphoritis, cellulitis, adenitis, lymphangitis, peritonitis, being the diseases mostly to be sought for.

Puerperal septicæmia includes besides the above puerperal infections, pleurisy, pneumonia, pericarditis, phlegmasia alba dolens, phlebitis, endocarditis, hepatitis, nephritis, arthritis, and it is evi-

dent that while one name includes them all, the necessity exists for their careful and distinct differentiation. This is necessary in order to the proper treatment of the disease, for manifestly it is better to cleanse the fountain than tamper with the stream. The septic condition may not be confined to one organ or set of organs, but may implicate nearly every organ in the body, particularly the glandular. In such a case, the complications render diagnosis difficult, the conditions being mistaken for typhoid or other similar fevers. In one case had by the writer several years ago, a lying-in woman was taken with rigors and fever on the second day. Search revealed no cause, and yet "puerperal fever" was suspected, and for a day or two believed to exist. The sequel proved the disease to be small-pox.

During the puerperium, we should ever be on the lookout for septic trouble. That we can have fevers during this period which are not septic or zymotic, is undoubted; but every rise of temperature within several days following child-birth should cause attention to be directed to septic trouble as the possible, and even probable cause. The writer has seen the temperature rise high in a woman on the eighth day following confinement, the result of too much company and excitement on the occasion of the circumcision of her child. In another a sudden death in the family caused chill and fever in the puerperal woman. But, in each of these cases, there was substantial ground for *fearing* puerperal infection.

It is a good plan, after child-birth, to take the temperature, and make a note of it on paper. The nurse should be instructed to take it at intervals of at least three hours daily during the two weeks of the "lying-in." At the first intimation of chill or creeps on the part of the patient, the thermometer should be used. The physician should be notified immediately on the indication of a rise in the temperature of the woman, and he should thereupon visit her and thoroughly investigate the cause of the pyrexia. The only septic disease of the puerperium not accompanied by fever is, perhaps, septic catarrhal vulvitis and vaginitis. In diphtheritic vulvitis and vaginitis, endometritis, metritis, and thereon through the whole list of septic diseases before enumerated, there are chill and fever, of a more or less high grade. This shows the supreme necessity of being on the alert for these manifestations, since their early detection will very materially simplify our care of the patient.

At the onset of a chill or fever, septicæmia being our first thought, we should immediately examine the vulva, vagina, uterus and the

lochia for evidences of sepsis. These showing negative signs, the other pelvic tissues should be next investigated.

Not every case of puerperal septicæmia has such well-marked symptoms or manifestations as to permit quick and certain identification. The post-mortem table sometimes is the only sure revealer in these cases. But such an examination of the sick, if it does not locate the cause of the trouble, certainly does limit our responsibility in the future of the case.

Recognizing the fact that puerperal fever is not an entity by itself, but that it is simply a term grouping together many separate diseased organs or tissues, all caused, however, by septic material, we neither search for nor treat, one entity as comprised in all cases, but we search for and treat the individual cause and the specially located result. Since this principle has actuated accoucheurs in their treatment of the puerperal-fevered woman, order has come out of chaos, and lives formerly lost are now saved.

But, after all, it is prevention, an ounce of which is worth a pound of cure. Prophylaxis guards the woman against infection, making diagnosis and treatment strangers in the lying in chamber.

What shall we, upon whom the pregnant woman places such confidence, do to provide her with a perfect prophylactic against septicæmia? This question is variously answered in the simple word "sepsis," or, if necessary, "antisepsis." Cleanliness, and if not simple cleanliness, then the destruction of disease-germs by antiseptics, guards the woman against her deadliest foes. Shall this asepsis be complemented by antisepsis, and is it possible to secure asepsis without the employment of antiseptics? Evidently, from the very nature of every woman's surroundings, whether high or low, in hospital or in home, no woman or her surroundings is aseptic. To make her and them so, antiseptics are necessary.

Doubtless many germs are washed away and rendered negative by the simple acts of cleanliness common with some women, absent with others, but essential in all. Clean clothes, clean bedding, clean surroundings, and a cleanly person furnishes the asepsis; under the accoucheur's direction the antisepsis is supplied by, best of all, mercuric bichloride

When the moment arrives that the woman feels she is having delivery pains, she should change all her clothing for clothing thoroughly boiled, ironed and laid away in a clean and tight drawer. She should have washed herself and taken a douche of warm water with mercuric bichloride in it, one part of the latter to three thou-

sand of the former. The syringe should be a fountain syringe never used before. The sheets on the bed should be changed for those which are clean. The patient should supply clean cloths and napkins, made new, if possible, boiled, ironed, dried and set away for use.

The accoucheur needs to be clean, and he needs to disinfect himself before examination of the lying-in woman. The rules governing him are those governing the surgeon, the washing of his arms and hands in bichloride solutions (1 : 2000 or 1 : 1000), their scrubbing, etc. A bichloride sheet should envelop the accoucheur. The nurse must be disinfected both as to her person and her clothes.

Everything used in the confinement must have been scrupulously made clean before contact with and use upon the patient.

After the labor, the vagina and uterus should be freed from all foreign material and disinfected by douches of very weak bichloride of mercury (1 : 6000 to 10,000) carbolic acid (1 per cent. sol.) or creolin (1 per cent.).

As little manipulation during the act of labor and following it should be done as possible, and then always with the hands wet with the bichloride of mercury or other antiseptic solution.

After the delivery of the child, the placenta should be delivered in such manner, if possible, that the accoucheur's fingers shall not have entered the vagina.

The post-delivery examination for rents, etc., of the perinæum and vagina, should be made under antiseptic precautions, following which is given a douche.

Antiseptic pads should be used for the dressing, and the whole puerperium should be made subject to antiseptic rules.

I have found this paper to have grown so large under the running method adopted, that to say much of the treatment of puerperal septicæmia is impossible. If the infected parts can be discovered, they should be exposed, disinfected and treated. Retained clots, *débris*, etc., in the vagina and uterus must be removed, the parts disinfected and the condition treated. Wounds apparently or really infected ought to be reopened and disinfected. If the pelvic organs are diseased, treatment specially directed to them is to be instituted. If the infection has passed to other organs, they, too, need to be individually and specially treated.

Leptandra is useful in typhoid fever with symptoms of a bilious character, when the stools consist of black blood, looking like pitch.

OTITIC BRAIN ABSCESS.

AN ADDRESS BY DR. JANSEN BEFORE THE BERLIN MEDICAL SOCIETY,
OCTOBER, 1891.

(Translated from *Berliner Klin. Wochenschrift* by Charles M. Thomas, M.D., Philadelphia.)

I HAD hoped to be able to present to the society a case of "healed abscess" in the right temporal lobe which had been caused by an acute suppurative "otitis media;" instead of the convalescent patient, however, there arrived this morning the news of his death on Sunday last. I take the liberty, nevertheless, of reviewing this case, inasmuch as it furnishes an example of the uncertainty of healing in brain abscess, and of the importance of holding such cases under prolonged medical observation. The case is that of a locomotive driver, 46 years of age, who had never suffered from disease, except rheumatism, and whose ears had always been sound. In April both ears were attacked with deafness and tinnitus. In May, pain set in in the right ear and mastoid process, swelling appeared over the mastoid, which, however, soon subsided. By the end of June the pains in right ear were more severe, and radiated through the whole right half of the head, particularly the forehead and temple. The headache was almost unbearable. By the middle of June the mastoid swelling had reappeared, accompanied by vertigo and nausea without vomiting. The memory was much impaired. No discharge was ever present. At the time of his admission, August 3d, of this year, there was no fever; a rapid pulse; no vertigo; no paralysis; strength fairly good; drum-head swollen and dull red, with no perforation; the hammer not perceptible; the mastoid noticeably swollen at its apex; the hearing much impaired; severe pain in the right half of the head; no tenderness on percussion. On the same day the mastoid was opened with the chisel, and a fairly large empyema found, which was freely exposed without opening the middle fossa. Following the operation, it was found that the right-sided headache persisted, though lessened for a short time. On the fifth day after the operation vertigo appeared, and on August 9th slight weakness of the left arm, and on the following day, paresis of the facialis and of the left lower extremity. From the 10th to the 17th there was a gradual slight increase in the paralysis; drowsiness set in, together with further impairment of hearing, and finally vertigo and vomiting, the headache remaining unchanged. Neither choked disc, fever, nor slowing of the pulse was found.

Dr. Oppenheim was good enough to examine the case the day before operation, with the following result: moderate stupor, conjugate deviation of the eyes and head toward the right, impaired ability to turn head and eyes to the left, distinct left-sided hemiparesis with almost complete paralysis of the left arm, constant mild twitching over the area of left facialis, distinct left homonymus hemianopsia, left hemianæsthesia, tendon reflexes somewhat exaggerated. Diagnosis: Brain abscess so situated as to involve (directly or indirectly) a posterior part of the internal capsule and posterior segment of the thalamus opticus. It was decided, on account of the variation in the intensity of the slowly increasing character of the paralysis, that the abscess was to be sought, not in the region of the inner capsule itself, but at a point contiguous to the suppurating middle ear; hence, in the temporal lobe close to the tegmen-tympani, and that the existing symptoms were the result of hyperæmia and œdema of the brain substance about the posterior crust of the internal capsule and of the pulvinar.

On August 18th an opening, the size of a two-mark piece, was chiselled in the squamous portion, the lower edge of which lay a half centimetre above the external meatus, the anterior about in a line with the anterior meatal wall. The dura appeared tense, without pulsation; showed no discoloration or sign of pus; was elastic and did not bulge into the bony opening. In the centre of the exposed dura, a puncture 2 c.m. deep was made with a 3 mm. trocar, running inward, forward and upward, and a considerable quantity of pus evacuated; the dura was then opened freely by a crucial incision; the arachnoid showed no change beside a mild hyperæmia. An incision with a knife in a line of the trocar puncture was followed by no further appearance of pus. The introduction of the little finger revealed a small cavity surrounded by soft brain substances. The brain now pulsated forcibly. The abscess cavity was lightly filled with iodoform gauze. No cerebro-spinal fluid appeared during the operation.

The evacuated pus measured about a tablespoonful, and was of creamy consistence and odorless. On the evening after operation there was a perceptible aggravation of the motor paralysis, and the temperature arose to 38.8° C.; consciousness was improved and the headache had disappeared. The following day paralysis began to improve, and the disturbance from hemianopsia had entirely disappeared. On the second day after operation the sensory paralysis was well. On the fifth day, perfect motion was restored in the lower

extremity, and on the seventh, the arm paralysis was entirely gone. The hearing in the sound ear was variable, but upon the whole improved. The middle ear still continued to exudate.

There still remained a dilatation of the right pupil, slight weakness of the facial nerve, impairment of the memory, and a moderately rapid pulse. At the first change of dressing, on the second day, no further pus was found; and, on the seventh day, the abscess-cavity was closed, the brain-substance appearing slightly prominent. On October 12th, the parts were entirely healed, and the patient left the hospital. On the 17th the patient, without my knowledge, made a long journey home, to attend to financial matters, and shortly after was attacked with vomiting. Within two days, brain-symptoms showed themselves; speech was difficult, and his tongue was protruded to one side; paralysis of the left face, and spasm and paralysis of the left extremities with unconsciousness were promptly added. Protrusion and strong pulsation of the scar showing themselves, the parts were laid open, but no pus was evacuated. Death occurred four days later.

In reviewing the clinical course of this case, it will be noticed that no positive sign of cerebral complication existed before the opening of the mastoid process. The weakness of memory complained of, was of so vague a nature as to require no consideration.

Headache, vertigo, and vomiting, are sufficiently common with disease limited to the mastoid, and are very frequently found in labyrinthine affections. The condition of the mastoid at the time of operation, furnished not the slightest ground for suspecting intracranial complication; the tegmen tympani could be seen by reflected light, and showed no indication of disease; the dura was not exposed. It was only after the mastoid had been opened, that the persistent right-sided headache, and appearance of vertigo on assuming the upright position (fifteen days later), led to the suspicion of intracranial complication, and the beginning motor-impairment (six days *post op.*) in face and leg without producing irritative symptoms, first indicated the possibility of brain-abscess, and furnished a foundation for a fair localization of the trouble.

The certainty of the diagnosis was increased by the first appearance of somnolence, sensory disturbance, and the hemianopsia, twelve to fourteen days after the first operation.

The abscess, therefore, with its surrounding zone of softening, must have started in the lower portion of the temporal lobe, where, beside pain, vertigo, vomiting, and impaired memory, it gave no

evidence of its presence, and thence moved gradually forward, and upward and inward, toward the post. crus of the internal capsule and pulvinar. It is not supposable that the evidence of the development of the brain-abscess was caused by the mastoid operation, although, on account of the thickness and density of the mastoid cortex, a considerable amount of concussion with the mallet and chisel was unavoidable.

The question as to the diagnostic worth of the impaired hearing of the opposite ear, which appeared in conjunction with the more positive brain-symptom, is not easily answered, as to whether it was to be looked upon as a paretic symptom in consequence of lesion of the cortical auditory centre, or its conducting tracts in the oppositely-lying temporal lobes; as a separate deafness of that ear, resulting from the presence of middle-ear exudate; or, finally perhaps, as only one of the manifestations of the general somnolent state of the patient.

Of the other cases of brain-abscess which have been under observation, I will consider the clinical course of but two of the most interesting:

Max E., 34 years old, had suffered from left-sided offensive otorrhœa following measles. He was otherwise well. On July 18, 1891, he was suddenly attacked, after a meal of fat sausage and fresh bread, with chills, vomiting, and headache, particularly at the vertex; a temperature of 39° C., and very foul tongue. On the night of 20-21 delirium set in; during the day the mind was clear. Diagnosis of house physician was typhus.

On the 20th, the patient became much excited, with difficulty in recollection of certain words. During the following night, great pain at vertex, restlessness and sleeplessness. On the 23d, fever had disappeared; and, on the 24th, the patient went out. On the 25th, the condition was as follows: Patient feels weak, but does not appear very ill; is apathetic whenever left to himself. Repeats his words often; at times cannot find the right word, or confuses one word with another, and complains of constant pain in vertex. Neither slowing of pulse nor percussion sensitiveness was present; the mastoid process, externally, appeared sound; there was no vertigo and no palsy.

The ophthalmoscope shows no special change; hearing in sound ear is very good; tongue coated; bowels constipated. During the night of the 28th and 29th, great restlessness and delirium developed, with protrusion of the tongue to the right side. Before morn-

ing he had sunk into complete coma, followed, in a few hours, by restlessness and, finally, right hemiplegia. Pulse and temperature remained unchanged, as also the ocular fundus. The location of the abscess was not attempted.

Without awakening from the coma, the patient died on the evening of July 1, 1891.

The autopsy gave the following: Gyri much flattened; sulci almost obliterated; the left temporal lobe was much enlarged and tense, and contained a large abscess filled with offensive green pus, surrounded by a thin capsule, which was found adherent to the underlying dura mater and tegmen tympani. The tegmen is carious and fistulous. The abscess is surrounded by a broad zone of softened, almost fluid, brain-substance; the floor of the ventricle is greatly compressed by the abscess; the ventricle contains a small amount of clear serum; the frontal convolutions showed flat ecchymoses; the sinus was empty; between the dura and tegmen tympani there was but a trace of pus; in the antrum and upper part of the drum cavity there were masses of cholesteatoma. . . .

The third case of brain-abscess was located in the occipital lobe, and did not accompany the ear disease, but appeared during a suppurative inflammation in the respiratory apparatus, and but secondarily involved the temporal bone.

A boy of 8 years lay six weeks with severe fever, diarrhoea, coated tongue, and frequent chills. The temperature curve was that of a grave suppurative fever.

The disease was supposed to be typhus. A number of weeks before the attack the patient had complained of frequent headaches, with vomiting, and his gait had been noticeably staggering. The mental state had never been impaired. In the third to fourth week of the sickness, the neck grew very stiff, and the head lay almost constantly forward and to the left. A week later, one of the ears discharged for a few days, without pain or impaired hearing having been noticed. Eight days later a painful swelling appeared behind the right ear, on account of which the patient was brought to the ear clinic. A number of days before the patient had complained of bad sight and double vision. On his reception, August 25, 1890, the patient was found to be much emaciated, jaundiced, and apathetic. Pulse rapid; no fever. The eyes showed no special changes either in the pupil, muscles, or fundus, nor was there diplopia. Hemianopsia was not examined for. Over the mastoid process, posteriorly, there was found a large periosteal abscess; the membrana

tympani showed no scarring, but was, however, opaque and dull; hearing fairly good. At the operation, on August 25th, there was found, about three centimetres behind the meatus, on a level with the upper meatal wall, a fistula in the bone, which led to a large extra-dural abscess on the lateral and anterior aspect of the cerebellum. The dura was much thickened, and covered with granulation tissue, which was removed with the spoon. The pus was excessively offensive. The mastoid antrum was not involved in the suppurative process.

The day after the operation the patient was well, cheerful, and without complaint. On July 20th, fever, without chill, set in with pulse 162, and a slight facial paralysis, to which was added, on the 28th, frequent facial twitching and almost complete paralysis of the left arm and marked lessening of surface sensibility. The lower extremity was involved but little in the motor paralysis, and not at all in the sensory. On the 29th, the patient was comatose. In spite of the apparent hopelessness of the case, and the probability of the existence of a meningitis of the convexity, the patient was trephined.

Through the incised dura over the temporal lobe, there was evacuated a large quantity of foetid pus. Following this, there was temporary improvement. Death occurred four weeks later. At the autopsy there was found not only an abscess in the right occipital lobe, about one centimetre from the posterior horn, and a sinus thrombosis, but also a bronchiectasia, the size of a pigeon-egg, in the right lung, filled with thick pus.

An examination of the records of the University ear-clinic, in relation to otitic brain abscess during the past two years and a half, shows, in a round 13,000 cases, 8 of them complicated with brain abscess. These are found included in 354 cases in which the mastoid was chiselled. If the case just related be excluded as one in which the temporal bone was but secondarily involved, there remain 7 brain abscesses as occurring in 5000 inflammatory and suppurative processes of the middle ear. The brain abscesses were found four times on the right side and three times on the left side; four times in the cerebellum (three right, one left); three times in the temporal lobe (one right, two left). The cerebellar abscesses were three times complicated with thrombosis,—one of the sinus transversus, one of the sinus petros superior, one of the vena audit. int. One temporal lobe abscess was accompanied by thrombosis of the sinus transversus. With both sinus thrombosis sepsis was present. . . . All 7 of

these brain abscesses lay close against and behind the diseased temporal bone; in 4 cases in direct communication with the empyema of the mastoid. This fact is of great importance in those cases in which localization of a supposed abscess is impossible on account of the comatose condition of the patient. . . . In all chronic cases the abscess contained exceedingly offensive green pus. A capsule was always present, although in one case it was so soft and friable that it could not be separated from the brain substance. The abscesses were always surrounded by a zone of cedematous, softened brain substance, even in those cases where the autopsy was made immediately after death. The cerebellar abscesses were all accompanied by labyrinthian disease, in one case of which there was cedematous swelling and redness of the membranous semicircular canals, in two other cases an empyema, and in a fourth a complete destruction of the bony labyrinth. In the abscesses of the temporal lobe there was no macroscopic pathological change in the labyrinth found. The mastoid process was diseased without exception. In four cases empyema was found; in three cases, cholesteatoma. In two cases, the mastoid process appeared sound externally; in three others, sensitiveness to percussion was the only abnormal symptom. The chronic otorrhœa had existed in three cases since childhood, in two cases but half a year, and in one case but seven days following a three years' interval of relief. The cause of the otorrhœa was measles in two cases and unknown in five. The pus, in all cases except that of the acute otitis, was highly foetid. All the patients with chronic suppuration were attacked, while apparently well, with sudden prostration and fever. The course of the disease was rapid. Death followed an illness of seven, nine, eleven, thirteen and twenty days respectively. Death was apparently never caused by rupture into the ventricle or the meninges. Occasionally, paralysis of the respiratory centres was the apparent cause of death. In spite of the short illness, four of the patients were extremely emaciated; in five cases there was icterous discoloration. The first symptoms in all the cases were headache and vomiting. The pain was in three cases on the side of the affected ear; in the remaining ones in the region of the vertex, forehead, and occiput. During the course of the disease vomiting was almost constant; in three cases accompanied by vertigo, in one of which the temporal lobe was involved, while in two cases of cerebellar abscess vertigo was absent. There was stupor in six cases, and in one case of cerebellar abscess the sensorium was clear. One patient, with temporal abscess, showed excessive rest-

lessness. In two others, in the same location, impaired memory was noticed. A more or less pronounced stiffness of the back of the neck was found in all cases of cerebellar abscess. Much fever was only noticed in cases complicated with thrombotic changes. In one case of cerebellar abscess, this disappeared upon opening the mastoid. Slowing of the pulse was never observed. Percussion sensitiveness was far from constant. In one case of cerebellar abscess choked disk was noticed, most marked in the eye of the affected side. As a general thing, choked disk in intracranial suppurations is not present. The pupil of the affected side was dilated in one case. Neither albumin nor sugar was found in any case. The tongue was usually coated and constipation marked. Paresis appeared in three cases of temporal abscess (motor, sensory, aphasic, two each). Hemianopsia was noticed once. The aphasic disturbance occurred in the left temporal abscesses. The abscess in the right temporal lobe was accompanied by no disturbance of speech. In but one of the three temporal abscesses was the opposite ear sound and of good hearing power. In the others, the impairment of hearing could be accounted for by the objective changes in the middle ear. In but one abscess (temporal) of the operated cases was a correct diagnosis and localization made. A probable diagnosis without localization was made for a left temporal case, the only one in which the mastoid was not opened. An intracranial complication in general was suspected in two cerebellar abscesses, while in the remaining three cases the true condition was unsuspected up to the time of the post-mortem examination.

CERTAIN POINTS PERTAINING TO THE DIETETIC MANAGEMENT OF
DISORDERS OF DIGESTION IN PARTICULAR, AND OF NERVOUS
DISEASES IN GENERAL.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

REST is one of the first principles in the treatment of many chronic local disorders. This agent, so valuable elsewhere, cannot be applied to disorders of the stomach and intestinal canal with the thoroughness so often practiced elsewhere, because of the urgent demands of nutrition. In the case of acute gastric disorders it is a very simple matter to give the diseased organs rest, simply because the gen-

eral system is, as a rule, in the best of condition so far as nutrition is concerned, and abstinence from food has only to be maintained for a few days. In chronic diseases the general nutrition of the patient is bad, and the prolonged rest that is required is oftentimes impossible without resort to rectal alimentation. Rest being out of the question, it only remains for us to give food in such a condition as to throw as little labor as possible on the digestive tract. In doing this, we must, however, bear in mind the necessity of the system for food. I am well satisfied that it is only too common a practice to treat our dyspeptic cases by too rigid dietary measures, measures, in many cases, amounting almost to starvation. A teaspoonful of this, that, or the other patent food is given, three or four times daily, in the absurd hope that four drachms of "stuff" will not only sustain life but will perhaps restore the patient to health. In making this extreme statement I am not overdrawing the picture a particle. Only a few weeks ago I was called to see a woman of thirty years of age, a sufferer from "dyspepsia" for over two years, becoming progressively worse. To give her symptoms in a general way, she complained of an inability to retain any nourishment whatever; she was markedly emaciated. Gastralgia was severe. There was one spot over the epigastrium, in particular, that gave rise to considerable suffering. The bowels did not act regularly; and when a stool was secured it was heavily coated with mucus. Headache was severe, though not constant. Menstruation was painful, and leucorrhœa profuse. Her treatment had consisted solely of the internal administration of a food preparation very popular among the profession, one teaspoonful three or four times daily. That this "food" kept her alive is to its credit. To have expected it to give her strength was the height of absurdity. The method of feeding was at once changed. She took one pint of peptonized milk in the first twenty-four hours; and in the course of a few days was taking a full quart. At the end of ten days she began to eat bread spread with a thick extract of malt. Still, any further addition to her diet aggravated the epigastric pain. I then began lavage, and have followed each washing by the administration of one pint of peptonized milk through the tube. Thus far improvement is as great as can be expected. Pains, headache, prostration, nausea, etc., are all relieved. The case is still under treatment, and the ultimate result is as yet enshrouded in doubt. I simply introduce the case here, as it is a handy illustration of the class of patients who should not be subjected to the starvation diets now only too common.

It is absolutely necessary in such cases as the one above mentioned to order a diet that shall be sufficient to nourish the patient and at the same time subject the stomach to as little irritation and work as possible. This, I think, we will secure by the aid of predigested foods. Of these my preference, often my sole reliance, is peptonized milk. This agent will prove of value even when ordinary milk, though of good quality and taken properly, disagrees.

Robert G., æt. 39 years, consulted me December 6, 1890, on account of a persistent vomiting from which he had been suffering for three months previously. Hardly an article of food taken but what was vomited. Prior to the onset of the vomiting he had been feeling wretchedly for several weeks, but thought nothing of it. His appetite was poor. He had severe pain in the epigastrium just before he vomited food. Vomited matters were more or less yellow; they never contained even a streak of blood, and never had the appearance of coffee-grounds. Bowels constipated. Physical examination gave negative results aside from eliciting some epigastric tenderness. The patient's appearance was not at all cachectic. He was put upon an exclusive diet of peptonized milk, five pints to be taken daily, and *nux vomica* 2x prescribed. Improvement began at once and continued for two months, when he had a relapse from indulging in buckwheat cakes. The peptonized milk was kept up until the middle of March as the main article of diet, when he returned to his ordinary habits. This patient has since had two recurrences of the vomiting, but has obtained prompt relief on both occasions from the treatment pursued in the first one.

As to the use of the digestive ferments, there really seems to be but a limited field for them, administered in their pure state internally. Malt, as ordinarily given for its action on starch, is certainly useless. This agent exerts its diastasic action on starch only in the presence of an alkaline or very feebly acid reaction. The ordinary acidity of the stomach after the ingestion of a full meal is sufficient not only to prevent its diastasic action, but to destroy it permanently. The inutility of administering malt in given doses immediately after meals is thus made apparent. But recently, the agent for a house manufacturing a very good malt extract exhibited a prescription for the use of his commodity that for pharmaceutical incompatibility certainly deserved a prize. The mixture consisted of malt, sherry wine, dilute muriatic acid, and pepsin. Here was an agent capable of acting only in the presence of an alkali, whose action indeed was permanently destroyed by a certain amount of acidity, combined

with another (pepsin) which acts in the presence of an acid reaction. Yet because that prescription is peddled about from office to office, it will be utilized by the many who will not think for themselves. This, of course, does not detract from the value of malt, for there is a right way of using it. As already intimated, I have used the thick, treacle-like preparations, as maltine and Trommer's malt, spread on bread, with advantage, giving the patient directions to see that the food is thoroughly chewed. Roberts, in his little book on *Digestion and Diet*, recommends also an infusion of malt, which, he says, has diastasic properties fully equal to the best malt extracts. This infusion is prepared as follows: Three heaping tablespoonfuls of crushed malt are mixed with a half pint of cold water, and allowed to stand over night. In the morning this is filtered. It is used either by taking with a meal or by adding to gruels, etc. In the latter case, the gruel is first prepared, and when sufficiently cool to be tolerated by the tongue, the infusion of malt is added. One tablespoonful of the infusion is sufficient to digest one-half pint of gruel. In a very few minutes the gruel becomes thin from the conversion of the starch. In some cases the use of the dry malts may prove convenient. These, as well as the malt infusion recommended by Roberts, I have never used. It should be remembered that the latter spoils very easily, and should be made fresh each day.

Pepsin is the only digestive ferment that can be given by the mouth, and permitted to act under normal conditions. It is not as useful as ordinarily believed to be, and when useful it is not as effectual as we could wish.

As to pancreatine, it, like malt, acts only in an alkaline medium. Its activity is permanently destroyed by the normal acidity of the stomach. It is ordinarily held that the action of pancreatine remains in abeyance while it is in the stomach, to be restored as soon as it enters the duodenum. This is a mistake. Whether the tablets of pancreatine on the market overcome this difficulty or not I do not know. I have used them, and have thought I obtained good results from their administration. If their sugar-coating is dissolved before they leave the stomach, their action must be sadly interfered with.

The objection made to digestive ferments that their use suspends the performance of a normal function is not valid. They give the stomach the rest it requires, and their use is not persisted in for a length of time likely to prove injurious. It is, of course, other-

wise with their indiscriminate use by the laity on any and all occasions.

There is a rapidly-growing class of invalids who suffer from what has been called indifferently nervous dyspepsia, atonic dyspepsia, and gastric neurasthenia. In them all attempts at dieting usually fail of their intended purpose. If dieting does anything in these cases, it is usually harm. A certain article of food is found to disagree, and is forever discarded; another article follows it very shortly; and so it continues until the patient is living on the merest necessities of life. And yet they do not improve. Many of them, if taken away from home, and removed from the cares and anxieties of their routine life, are apparently well. They partake freely of all the viands placed before them at the large hotels, and seem to be all the better for their indulgence. They remain well for a short time after their return home and to their work, and then their sufferings are renewed. Such persons require, above all things, a rich dietary. Starvation treatment is the worst possible thing for them. Good moral management is also necessary. They must be made to feel that the trouble is not dangerous to life or to reason. The cause of the exciting neurasthenic state must be carefully sought and removed. In some cases it is excessive sexual indulgence, and impotence is present. Here the use of the cold steel sound, two or three times a week, and regulation of the sexual function, are inestimable aids. In one of my cases the cause was due to suppression of the sexual desire to avoid additions to the family. Proper indulgence was fraught with the best results. The best diet in these cases is one of highly nitrogenous food, with a certain amount of fats. The patient must eat the fat that goes with his piece of meat. Starchy food does not seem to be the best for these cases, not because of the liability to flatulence, but simply because it is not a good nerve nutriment. To supply the full amount of fat, cod-liver oil is often useful. This diet will seem almost certain death to the patient, yet it is astonishing in how many cases benefit follows from it. All the sufferings arise from a sensory neurosis of the stomach; there is nothing the matter with its digestive functions. Feed up the patient, give him a good nervous system, and you have done everything.

Coffee has been condemned for these people. In many cases, not in all, this is a serious mistake. If the coffee is prepared as it is by most cooks, it ought to be condemned; but, if prepared without boiling in the French coffee-pots, now becoming so popular, it will prove a valuable therapeutic adjunct. In atonic and in fermentative dys-

pepsia, alike, is it useful; but it should be administered without either sugar or milk. I, myself, can testify to the rapid relief obtained, when, on one occasion, certain dietetic transgressions gave me a severe fermentative dyspepsia, from which I obtained an almost immediate relief by means of a cup of coffee prepared without boiling. Coffee thus prepared is practically a pure infusion of caffeine.

As a means of prescribing fat for a nervous patient, I know of nothing better than the pork-sandwich first formally brought to the attention of the profession by Seguin. It is prepared as follows: A piece of the salted side of pork is boiled thoroughly, and put aside until cold, when it is placed in the refrigerator. From this are cut slices as thin as possible. These, with thin slices of bread, and flavored with Worcestershire sauce, constitute the pork-sandwich. The very mention of this dish is apt to excite opposition from the patient, but it is the exceptional patient that does not take it with relish, when properly prepared.

The regulation of the diet, not only in the case of dyspeptics, but in other people also, is one of our most difficult problems. Have we not, all of us, felt puzzled for an answer, when asked the question: "Doctor, what shall I eat?" We may say avoid starchy food, or do not eat dark meats, avoid fried food, or, some other practical evasion of a legitimate question. We may be met with the proper question: "What constitutes starchy food?" etc. Or, we may find that that is just what the patient has been doing. The best plan to pursue is this: Ask the patient to prepare a list of all the articles of food entering into his diet list; have him designate the comparative frequency with which he partakes of this or that article, and make any marginal comments as to quantity of the same. Here one has before him, in black and white, the diet which has possibly done harm—or which, at least, is not the one best suited to the patient. It is an easy thing to go over the list thus prepared, run one's pencil through objectionable articles, make notes as to articles that should not be frequently eaten, see that the heavy meal of the day is not ill-timed, and, in fact, to attend to many other little things that will be suggested while reading the list. After making the amendments, hand the list back to the patient, and he there has his written instructions as to diet. Given him in writing, he feels their importance, and will attend to them more faithfully than he would to some such hurried direction as "eat plenty of meat," or, "drink plenty of water." About a year ago, I was examining a neurasthenic young lady. Her answers to my questions regarding her diet were to me

most satisfactory. Failing to find a cause for her apparent starvation, I asked for a written diet-list, and then learned that she was not eating enough to keep her in good health, and that little was not of the right kind.

The majority of people do not take enough water. A very mistaken notion prevails to the effect that it is bad to drink too much, because water dilutes the gastric juice, and interferes greatly with digestion. There is a right and a wrong way of drinking. To swallow a whole tumblerful of ice-water almost at one gulp, is unquestionably a pernicious practice; but to drink slowly, when there is no food in the mouth, is another matter entirely. A liberal supply of water is as essential to good health as is a good supply of food. Especially is the water important in patients who partake freely of nitrogenous food. One of the chief advantages of a milk diet is, doubtless, the large quantity of fluid introduced thereby into the system. The same is true to a less degree of the grape cure and the whey cure. To make what is a true comparison, if one wants a good fire, he must not only supply fuel, but he must make disposition of the ashes. We supply food to the body, the nutritious elements are assimilated, and we must provide a means for the elimination of the excrementitious substances. Water is the universal solvent. Just as we use it for washing and flushing our drains, so may it act to flush the system, and take away the excrementitious substances; to clear out the urea, uric acid, and phosphates, by the kidneys; to wash the liver; and to aid the action of the bowels. A glass of water on retiring, and another on getting up in the morning, is a very simple, and oftentimes efficacious remedy for constipation. I have often been very much surprised on inspecting my patients' diet-lists to find the very small quantity of water taken. Only this day, a man applied to me for the treatment of an universal pruritus. He was a highly neurotic subject, and had been so for ten or a dozen years. His diet consisted very largely of highly nitrogenized food; and yet he hardly drank four ounces of water daily. Among other things, he was directed to drink three pints of water daily.

There is not infrequently some difficulty in getting patients to take water in these unaccustomed quantities. This is usually overcome by ordering some of the well-known mineral-waters. Whether these waters have any real medicinal value aside from the H_2O , I do not know. My own opinion is in favor of the idea that it is water that does the work. There is a good deal of superstition surrounding this subject. Magnetic-waters and waters of other kinds are

credited with almost supernatural powers. Thus, one man will tell us that he has actually seen a urinary calculus dissolve in —— water. In other cases we see the labels on the bottles stating that the contained water cures dyspepsia, nervousness, lithæmia, gout, gravel, calculus, rheumatism, consumption, and Bright's disease. I feel that the time has come for us to know, beyond all cavil, if the mineral-waters do exert effects of which plain H_2O is incapable. There is one advantage, however, that does attend the administration of spring-water, and that is their purity is such that one can far more readily drink the large quantities necessary than if he were obliged to rely upon the quality provided for public consumption, at least if it is such as we get in Philadelphia.

The carbonated waters are of therapeutic value. In the first place, they unquestionably increase the salivary flow, and the saliva has digestive functions. Roberts's experiments apparently show a contrary result, as he says water charged with pure carbonic acid gas arrested salivary secretion. But when he employed the ordinary waters of commerce, which contain a slight amount of alkali in addition to the gas, this inhibitory effect was entirely removed. One need only to indulge in these waters for himself to find that they do excite a salivary flow; whether because they are pleasing to the taste, or from a direct stimulating influence, I do not pretend to say. Their use as table-waters is well-nigh universal. This practice must, therefore, be prompted by experience. Roberts has shown by experiment that they distinctly aid peptic digestion. This effect he believes is due entirely to the effervescence stirring up the stomach contents, thus securing a more thorough and a more prompt admixture with the gastric juice. It would hardly seem possible that this can be the proper explanation, for, taken as these waters are, in small sips in the course of a meal, there can be but little activity in the contained gas.

It has often been my feeling that disorders of digestion arise not so much from the actual character of one's food, as from the quantity taken, the manner and time of taking it, and the way it has been cooked. There can be no question of the oft-repeated assertion that more people die each year by excesses in eating than by excesses in drinking. Hasty methods of eating are likewise pernicious. It is not only imperfect mastication that is at fault, but deficient salivation also. Some can masticate their food very rapidly, but even then they do not prepare it for peptic digestion, for they do not retain it in the mouth long enough, or incorporate it thoroughly with the

saliva. The partaking of a full meal just before or just after violent exercise is bad. But cooking is of paramount importance. A good cook is a comparative rarity. What wonder then that mankind is a sufferer from indigestion. Brunton tells of a clergyman who eradicated drunkenness from his parish by having a dentist keep the teeth of his parishioners in perfect order. As much good, if not more, can be done by providing the world with a good supply of cooks. We may give our patients most carefully detailed directions as to what to eat, and as to how to eat it, but if the cook spoils it, our efforts go for naught.

Lastly, I want to speak of acid dyspepsia, and make a few remarks on the salivation of pregnancy. We are all, more or less, familiar with this variety of indigestion, and we have, perhaps all of us, realized its obstinacy to remedies. Perhaps our patients have sought relief for themselves in the administration of alkaline medicines. There is a very simple remedy at our disposal. Accompanying the extreme gastric acidity is usually an increased flow of an extremely alkaline saliva, this seeming to be a conservative process. Roberts has proposed that this effort of nature to give relief be encouraged, and he accordingly advised the use of an innocuous chewing-gum. This advice proved to be as good in practice as it was in theory. It is, without doubt, the foundation of the many varieties of so-called pepsin chewing-gums which flood the market, all of which are guaranteed to cure dyspepsia. It is the chewing that does the good, and not the hypothetical quantity of pepsin alleged to exist in the patent gums.

It is the therapeutic effect of chewing gum that has led to my introducing the subject of the salivation of pregnancy in this place. A few years ago I was much worried and distracted over a case of combined vomiting, salivation, and albuminuria in pregnancy. The patient had been pregnant three times, and each pregnancy had followed the same course. Vomiting set in about the fourth week, the vomited matters having a most intensely acid odor, the act being repeated many times in the course of twenty-four hours. Salivation came on one week later. About the fourth month in the first, and in ten weeks in the other two pregnancies, albuminuria was discovered, and this increased until the urine became almost solid under the heat and nitric acid test, and then miscarriage occurred. All treatment was in vain. Remedy after remedy was carefully selected; local washes were used. Tampons were applied in the hope that support of the uterus would help. Once the application of iodine

to the inside of the cheek suspended the salivation for one day. In the third pregnancy, my friend, Dr. Dunning, suggested the use of spruce gum for chewing. This was tried. The result was remarkable. I do not think that the salivation was lessened by this agent; but it was made more bearable, and was readily swallowed by the patient. Simultaneously the vomiting ceased, and the albuminuria diminished. But it was too late, for the constitution, weakened by the triple drain, was unable to continue the pregnancy, and miscarriage resulted as before. There were two theories to account for the salivation and albuminuria. The first is, that the patient was a highly neurotic subject, and that both troubles were reflex. The other is, that the intensely acid condition of the stomach had excited the salivation, and had likewise produced an auto-intoxication, this latter producing the albuminuria. At any rate, the above are the facts in the case, and that the symptoms were markedly relieved by chewing an innocent gum is highly interesting. The ordinary spruce gum as sold in the shops was taken and boiled until all the oils had escaped. Then the water was poured off, and the portion of the gum remaining was used.

RHEUMATISM, ENDOCARDITIS AND CHOREA.—Under the title of the kindred of chorea, Sturges considers the relation of the above-named affections. He formulates the following conclusions:

1. Recent endocarditis with no further heart change is the cardinal anatomical feature in those dying with chorea without reference to rheumatism. Yet it is not constantly found, and some of the most striking examples of deaths by chorea are without it.

2. Choreic endocarditis is distinguishable from rheumatic endocarditis both clinically and anatomically. Clinically it is without physical or general signs, often without rheumatism, and only discloses post-mortem. Anatomically the inflammation is recent, its chief, its only seat, is the mitral valve, and there are no consecutive changes in the heart. The contrast to this condition is seen in the rheumatic children with valve disease who are or who have been choreic. In them the physical signs observed during life correspond with well-recognized changes in the valves and heart chambers found after death, and due to the rheumatism and not to the chorea.

3. Choreic endocarditis, therefore, is not accurately described as a manifestation of rheumatism. Both chorea and rheumatism are liable to this inflammation, each after its own manner. The common feature may be taken as evidence that the two affections are pathologically allied, not that either of them is a form or expression of the other.

4. The fact of this alliance is best seen by the observation of chorea in very early life, at which period it is very often intimately associated with rheumatism polyarthritis in the same subject and at the same time. But with growth in obedience to the natural history of the two affections respectively, and influenced by several accidents of life, this association is relaxed, and at puberty it has ceased to be intimate.

5. Both chorea and rheumatism are, it is probable, members of a pathological group which has arthritis as a common factor, and of whose underlying source we are yet in search.—*American Journal of the Medical Sciences*, December, 1891.

CORRESPONDENCE.

MIDDLETOWN STATE HOMŒOPATHIC HOSPITAL.

EDITORS HAHNEMANNIAN MONTHLY:

Gentlemen.—The last decade of the nineteenth century sees religious and political liberty well assured in most countries of the world, and nowhere more firmly than in the United States. It is thus gratifying to the friends of liberty, that in the fierce light of modern civilization the moles of religious and political bigotry have been swept away, and the intellectual atmosphere purified.

It remains, however, for the imperial commonwealth of New York to present the spectacle of the final struggle for complete liberty. There is going on a giant struggle for freedom of choice in medical matters, carried on by the State Homœopathic Hospital at Middletown, the champion of all homœopaths in our land, and in particular of the Empire State, against the bigotry of the old school, as manifested by the Allopathic Board of State Lunacy Commissioners. This struggle is, on the part of the homœopaths, a struggle to secure their inherent, natural and chartered rights; on the part of the commission to reduce the level of this hospital, throttle the action of its trustees, choke its growth with the weeds of bigotry and opposition, and centralize its powers of local self-government in themselves. Jealous of the progress made by the homœopathic hospital, a triumph for homœopathy, the commission, under the guise of the "State Care" humbug, as now operated, is striking right at the heart of homœopathic success, and doing all it can to cripple the efforts of our trustees to maintain the high grade of usefulness hitherto attained. Thus, it was jealousy of our success that started the opposition cry of "private patients excluding public patients," "the rich crowding out the poor," those claptrap and charlatan appeals to the unthinking and dissatisfied element of the people. Anxious to curry favor with their allopathic clientele, the commission at first issued an order against the reception of all private patients; later, modifying the same and making a ten-dollar limit the maximum that could be received from private patients. This order was directly levelled against us and excluded numbers of well-to-do patients desirous of homœopathic treatment and able and willing to pay more than ten

dollars per week. There was jealousy of our revenues derived from private patients, which enabled us to keep the hospital upon a high plane of comfort and usefulness. This was the underlying animus of the regulations issued with regard to receiving private patients. On this matter, in the 21st annual report recently submitted to the Legislature, Dr. Talcott says: "The cry that the rich are crowding out the poor from our State hospitals should be analyzed, the facts of the case should be examined and weighed, and then the real significance of the cry may be understood. On the 30th of September, 1891, the close of the year whose record is now passing into history, there were 1,306,925 cubic feet of air-space in the State Homœopathic Hospital at Middletown. Of this space, 32,865 cubic feet were used by patients paying more than ten dollars per week. The facts do not warrant the assertion that the rich are crowding out the poor." Thus it was hardly out of love for the pauper insane that the commission issued its order against receiving private patients. It was a clear case of allopathic pressure brought to bear upon an allopathic commission for the choking off of rising homœopathic ascendancy, the lessening of homœopathic revenues (we are out just \$24,000 per annum by the order) and consequent lowering of the high grade of usefulness to the sick previously attained. The commission, of course, for political effect, like to pose as the pauper's patrons; but it can hardly be expected of the homœopaths that they waive their just rights and lose necessary revenues for the sake of making political bricks of straw to prop up the shaky position of an experimental, hostile and anti-homœopathic commission. We do not propose to let the commission manufacture political buncombe at our expense. It would moreover seem, from orders issued by the commissioners, that they had made it their business to look after the pauper insane only, leaving the insane in moderate circumstances and the rich insane to shift for themselves, thus making the poor a privileged class, and making means and wealth a hindrance to the other classes and an obstacle to their obtaining the medical treatment they desire. Thus the broad and beneficent principle of "State Care" is made to cover the care of the pauper only, to the exclusion of the other two classes of our citizens. With regard to the "State Care" Act, we have this to state, and desire for it the utmost publicity of publication. The "State Care" Act was passed with a distinct and formal pledge that the rights of the Middletown hospital and of the homœopaths at large in this State would not be injured or impaired. As an actual fact, we state on the authority of

a member of the medical staff, that Dr. Talcott received a telegram stating that if he withdrew all opposition to the "State Care" Act, the act would be passed and would not affect the rights of the State Homœopathic Hospital at Middletown or of the homœopaths of the State. The act was passed and the pledge given by the promoters of "State Care," utterly, shamelessly and wantonly disregarded. This was direct evidence of hostility to this hospital, and merits the severest and most unqualified condemnation of all honest men. Our rights have been utterly disregarded by the commission. Under the "State Care" Act, as now operated, the homœopaths of 53 counties of the State are shut out from their own hospital, and unwilling allopaths in the Middletown hospital district (of 7 counties) are forced to go to a homœopathic hospital. To this general exclusion of homœopaths, add the fact that a rich homœopath living in the Middletown hospital district, who wishes to pay more than ten dollars per week for comforts and a special nurse, cannot come here for treatment, but must go to a private asylum, where the management, with "itching palm," is ready to receive him cordially, charge him exorbitant rates, and hold on to him as long as possible, and you have a view of the effect of the "State Care" Act and of the breach of faith of its promoters towards the homœopaths.

Let all homœopaths of the State unite and demand fearlessly either the repeal of the "State Care" act or its extension to cover all the insane, public and private, rich, in moderate circumstances and poor, for all are the wards of the State. If this cannot be at once accomplished, an amendment to the present law should be insisted upon, restoring to the Middletown State Homœopathic Hospital its chartered rights, and to the homœopaths, wherever resident in the State, full freedom in medical matters. Let them tear from the Commission the barnacles of bigotry, the growth and inheritance of centuries, and demand a homœopathic representation in the Lunacy Commission equal to the ratio of the homœopathic population to the whole population of the State. Let all citizens who prize local self-government oppose by voice and pen the efforts of the commissioners to centralize power in themselves, and render hospital trustees and officials mere puppets in their hands. In a later article we will speak more at length of the centralizing tendencies of the present Commission in Lunacy; at present we would direct attention to the Twenty-first Annual Report of the State Homœopathic Hospital at Middletown, as therein the medical superintendent speaks forcibly on the topics under discussion. Apropos of the rich and poor being all

wards of the State, Dr. Talcott says: "When the young, or those under age, have been bereft of their parents, who are their natural guardians, the court may appoint a guardian, making the helpless ward a minor, to be protected by such guardian. When persons of any age become helpless through an invasion of mental disease, then the State may make such persons its wards. Already the State of New York recognizes its duty of wardship over 16,000 helpless pauper insane. Here is an assumption of sympathetic guardianship over those who have life only to protect. But the State should go further, and protect all who are helpless, whether they be rich or poor. The rich insane have more at stake than the poor insane. They need to be protected both in life and property, and the purpose and aim of every State is to protect the lives and property of its citizens; that is the purpose of all good government. It has been claimed that the rich insane, having money, may take care of themselves; but the history of the world proves that the helplessness of the rich man when insane is so abject and deplorable as to tempt the eager cupidity of the avaricious. Hence, if unprotected by the State, the rich man is quickly despoiled of his property when insane,—sometimes even by his long-trusted friends, and sometimes by those who could not be classified as such."

And again the doctor says: "While writhing in the toils of this laocöonic disease, the richest man is as helpless as a child, and needs protection of life and property as much as the weakest and most ignorant minor. Without such help the fortune of a lifetime of earnest toil may be lost in a week; for sharpers follow in the wake of the rich insane as naturally and persistently as a shark follows a vessel when there is a corpse on board. The poor insane have already been recognized as the wards of the State by recent enactments, and we now ask that all of the insane—the poor, the private patients in moderate circumstances, and the very small percentage of rich—may be included in the benign category."

John Stuart Mill could not have stated the argument more clearly, simply, and logically, and we regret space forbids our quoting any more of this able statement. The extension of the present restrictive provisions of the "State Care" act would thus seem to be the duty of the present democratic legislature, so as to include all three classes mentioned in the above argument.

The report is equally forcible in its argument for "the proper management of State hospitals" by their local boards of trustees. Superintendent Talcott asks the question: "Why should State hos-

pitals be continued under the management of boards of trustees?" and answers: "For this reason. The history of the past proves that our State charitable institutions have been upbuilt and maintained at a high degree of usefulness to the sick under such management. As a rule, the trustees of our State hospitals are selected from among the best, most benevolent, and most unselfish men in the community." Our personal knowledge verifies this statement in the case of the Middletown Hospital. And again: "The fact that these trustees perform their duties without compensation, and yet with surprising zeal and fidelity, is a fact that ought to inspire the utmost confidence in their work throughout the community at large."

The system as in operation at the Middletown Hospital is most successful, and affords a striking object-lesson to the present Lunacy Commissioners, who, if we judge from their recommendations, are desirous of appropriating powers to themselves which good local self-government requires to be lodged in the trustees and officials of each hospital. The trustees here do not interfere with the details of executive work, which are done by the officials and a corps of clerks. The trustees look after the interests of the patients; see that their food is good, their quarters comfortable; arrange for the construction of new buildings; attend to the legislative interests of the hospital, and act as a cabinet or board of consultants to the medical superintendent.

With regard to the relations of the State Commission in Lunacy to the State hospitals, their trustees and officers, the Twenty-first Annual Report is equally clear and unmistakable in its position. The necessity of a central authority "to collect statistics, direct uniformity in non-essential matters, which shall pursue a broad and continued study of the best methods known or discovered in the care of the insane, and which shall likewise exercise a watchful guardianship over the general interests of the masses," will probably be conceded by all. But, on the other hand, any movement of such central authority to centre in itself the powers of local self-government necessary for each hospital should not be tolerated.

From recommendations made to the Legislature in the last two reports of the State Lunacy Commission, a tendency in this direction is noticeable. The commissioners would like to have the reports of the various hospitals sent to them and not to the Legislature, for they could then dole out to the Legislature just the amount of information that would be convenient. The commissioners would establish a central depot of supplies at Albany and purchase and

ship all provisions (of a certain grade, of course), to the respective hospitals, thus appropriating to themselves the purchasing and providing powers hitherto resident in the stewards of each hospital. Another startling suggestion made by the commission in their present report is that they should have the power to prescribe even the medical treatment in certain cases. These suggestions and recommendations manifest the desire of the commissioners to usurp powers so naturally inherent and so long resident in the local officers of each hospital, and cannot be too vigorously combated by all hospital officials, whether allopathic or homœopathic. On this subject Dr. Talcott says, "'State Care' for the insane should embody local self-government of the freest and best order, and likewise central authority, which shall oversee all the hospitals and wisely advise their managers and officers, and compel the best possible results in all of our charitable institutions. In accomplishing these ends there may be some friction; but it will be less in time if there are mutual forbearances, better understandings, and loftier determinations to perform one's own duty without infringing upon the rights and prerogatives and duties of others.

"In the execution of a great philanthropic labor there should be not only the wisdom of the serpent and the harmlessness of the dove, but there should be a quick and jealous determination to 'render unto Cæsar the things that are Cæsar's,' and to give to each hospital, and to each medical sect, and to local authorities and the central authorities, that freedom of thought and action which springs always from the monitions and impulses of eternal justice and of fair play." With this end in view, the Committee on Revision of the "Insanity Law" may well weigh the suggestions made by Superintendent Talcott in the 21st annual report of the State Homœopathic Hospital at Middletown as follows:

1. "A board (or boards) of commissioners in lunacy to supervise the management of all the lunatics in the State, whether rich or poor, whether confined in hospitals, asylums or private homes. Each board should consist of five or seven members, the majority of whom should serve without pay, except travelling expenses.

2. "The power of immediate management, of controlling expenditures, of making by-laws, rules and regulations, should be vested in a local board of managers, the majority of whom should live near the institution in order that frequent visits to the hospital may be made; and the members of such a board should be selected from

among the most active, benevolent and trustworthy men in the community."

For recommendations 3, 4, 5 and 6, we refer the reader to the report; recommendation 7 being perhaps the most important to the homœopaths, we will close our letter with that.

7. "Freedom of choice as to the treatment which shall be adopted should be guaranteed. Those who prefer homœopathic treatment should be admitted to the State Homœopathic Hospital at Middletown from any part of the State. This may be done by order of the county judge, or by his representative in each county. Those desiring old school treatment should be sent to the nearest or to the selected old school hospital. Until all who prefer homœopathic treatment are accommodated in the homœopathic hospital, no adherents of other medical beliefs should be admitted. When the homœopaths have been accommodated, and vacancies exist, then those having no choice, or those who are indifferent to the mode of treatment, may be admitted to fill the wards."

In conclusion we trust and hope that the present Legislature will restore homœopathic rights and enable the Middletown hospital under more favorable conditions to resume its career of usefulness to the sick.

Yours respectfully,

WALTER S. CLARKE.

MIDDLETOWN, N. Y., February 8, 1892.

A CASE OF GLANDERS CURED BY MERCURIAL INUNCTION.—Jacob Gold reports the case of a man, æt. 32, who became sick on June 20th. He first noticed a slight chill and diarrhœa and then pain in the right leg, with a swelling in the thigh as large as the palm of the hand, which extended into the subcutaneous connective tissue. In the lower part of the calf a comparatively large, longish lump could be felt. At the left external malleolus a circumscribed, round, livid red, fluctuating phlegmon of the size of a silver rouble, existed. There were fine vesicular râles in the lungs. A diagnosis of glanders was made in spite of the fact that the patient denied the possibility of any infection; and mercurial inunctions were made. The phlegmon was incised and in the pus from it glanders bacilli were found. Some of the pus was injected subcutaneously into a guinea pig which died on the fourth day, and presented all the characteristics of glanders, when examined after death. Cultures from the spleen on glycerine agar produced pure glanders bacilli. After 62 mercurial inunctions the fever gradually disappeared, the abscesses which had been opened healed, the lump in the calf became absorbed, and the patient began to gain in weight. The author remarks that when superficial, torpid indurations of the skin are found in a case or there are collections of pus, glanders must be thought of and mercurial inunctions instituted without delay in order to save the patient from an otherwise certain death.—*Monatshefte für praktische Dermatologie*, Bd., 13, No. 11, 1891.

EDITORIAL.

NON-SECTARIANISM IN THE PHILADELPHIA COUNTY MEDICAL SOCIETY.

FROM the newspapers of Philadelphia we have learned that Dr. John B. Roberts, President of the Philadelphia County Medical Society, in his inaugural address, recommended that the membership of the society be thrown open to all educated medical men regardless of school. The ostensible reason (a reason, too, that need not have been given to strengthen the position he assumed) for this course, he said, was that the number of homœopaths could be counted on his fingers. Dr. Roberts has long been closely identified with medical educational interests in Philadelphia. For many years he had charge of the Philadelphia School of Anatomy. He now occupies a responsible position in the Philadelphia Polyclinic (an institution which, we are informed, will not admit homœopathic graduates if they are known to be such); and he enjoys the confidence of his associates as is shown by his re-election to the presidency of the local society. He has likewise been prominent in all movements looking to the passage of a State-examining-board-bill in Pennsylvania.

Is Dr. Roberts sincere in making the above-mentioned recommendation, or is he doing it for effect by way of preparation for next winter's campaign before the Pennsylvania Legislature? That there will be a battle at Harrisburg at the Legislature's next sitting goes without saying. Worsted in two successive and bitterly fought campaigns, it is certain that the allopaths will return to the conflict with renewed vigor, increased experience, and less outward enmity, though with as much hatred of their victorious adversaries as ever. So far as Dr. Roberts is concerned we believe the recommendation comes with the utmost sincerity, offered for the good of the profession and the public.

We have not the slightest expectation that his recommendation will be adopted when the question comes up before the society for decision. On the contrary, the opponents of the measure will pack the meeting to the utmost extent and give it its Waterloo. How could it be expected to be otherwise? Look at some of the elements which go to make up the society. First, there is a gentleman who vies with the brave Kentuckian who declared that every homœopath

should be hung by the neck until he was dead three times. The Philadelphia belligerent has on numerous occasions made his hatred to homœopaths known through the newspapers and at society meetings. So far as we are aware he never speaks or writes upon scientific subjects. This same gentleman has lately given another example of his bigotry. He was called to a case in which three homœopathic physicians had been interested, and who, with one accord, had diagnosed organic brain disease with chronic Bright's disease. Although the physical evidence of such a diagnosis was overwhelming, this gentleman, rather than acknowledge that a homœopath could be right even once, chose to risk his own reputation for accuracy by saying that his predecessors had better attend lectures another winter, and that the man had neither Bright's disease nor organic disease of the brain, but simply nervous exhaustion. Another element of the society is to be found in the humane gentleman mentioned in our editorial pages of last month, and whose conscientious scruples would not let him help a supposed-to-be dying woman, simply because his next-door neighbor, a homœopath, had been first sent for. And another element is represented by what a lecturer before the Unitarian Club in Philadelphia, called medical bosses, and represented by the writers of flaming editorials, papers, etc., as recently published in one of our weeklies.

We say, then, that we have not the slightest expectation that Dr. Roberts' recommendation will prevail. But we give him all the more credit for the moral courage that he must possess for asserting himself in the presence of such belligerent elements.

But what of the justice of his position? Here we think there can be no question. Dr. Roberts is right. Medical societies should be thrown open to all educated medical men, regardless of sects and opinions. The common object of us all is to cure the sick, and our ambition is to become acquainted with those means that will best serve us in attaining that object. If the allopath finds that homœopathic medication will help his patients, he is untrue to himself, false to his trust, if he does not avail himself of their advantage. He commits a crime against his profession by following the course which has almost deified Ringer, Phillips, Bartholow, *et al.*, men who have appropriated homœopathic medication whilst denying the source of their knowledge. On the other hand we are homœopaths because we believe in homœopathy, and we practice it because we believe it to be the best for our patients. If it is not true, then we have no wish to follow it. We should abandon it forthwith.

Would not the acceptance of Dr. Roberts's recommendation kill sectarianism in medicine? To this we say both yes and no. If the recommendation is unanimously endorsed, with an endorsement that comes from the heart, we say yes most emphatically. If, however, it is accepted simply because the Society dare not go counter to its courageous president, then we say no. The millenium has not come, and we do not live in Utopia. The lion and the lamb cannot be expected to lie down with each other; at least not yet. The present outlook is that when the lion gets old, decrepit, and toothless, and the lamb sinewy and fleshless, that happy event may be; but not until then. From an abstract moral or scientific standpoint, sectarianism is all wrong. Americans should not be arrayed in great political parties, each seeking the other's destruction, but should endeavor to be American citizens. Christians, likewise, should not be divided into sects, but should content themselves with a religion that leads them to their God and a life of morality. Medical men should not be dominated by "medical bosses" (quoted from a lecture before the Unitarian Club, as reported in the Philadelphia daily papers), but should endeavor to have but one goal before them, and the cure of their patient as quickly and as safely and as thoroughly as possible. But man is not perfect, though he is fast getting there. In the present state of human affairs, men must hold widely diverse opinions in politics, in religion, and in medicine. It is natural that those holding certain views should flock together for the purpose of disseminating those views and converting unbelievers to their way of thinking. This is the foundation of an ethical sectarianism. But when the politician seeks to take unfair advantage over his adversary in ways only too well known; when the religious zealot refuses to listen to the logic of those who differ from him; when the medical schools exhibit an intolerance of each others views, each unwilling to accord the other as the possessor of one iota of truth; then we have a sectarianism that is inimical to the dissemination of truth. Sectarianism is wrong in the abstract, for on any one subject there can be but one opinion,—the right one. As we have said before, man is not perfect; he is often at fault. An ethical sectarianism, one entirely free from bigotry, is, therefore, necessary, not as an evil, but as a good for the advancement of mankind.

Is Dr. Roberts's recommendation in antagonism with the wishes of the homœopathic school? When homœopathy was first an institution in this country, homœopathic physicians were all members of old-school societies. Their acceptance of homœopathy led to their

expulsion, though not without considerable opposition on their part. Homœopathic societies were, therefore, made necessary. There was a time, then, when such a recommendation from an allopathic society would have been welcome. But in the present state of our institutions we cannot but view a new order of things with perfect indifference. We do not care whether it is or is not.

Will we join? No, we do not think we will. Self-respect will not permit of it. If we could join, give our opinions, and have those opinions respected and seriously discussed without prejudice, we might do so.

And, finally, are we in any better position than the allopathic societies? Do our societies admit allopathic physicians to membership? Some can, but none of them do. No allopath has ever applied, so far as we know. Our societies should be formed for the advancement of homœopathy, and we should admit to membership all physicians of the requisite educational skill. Knowledge and not creed should be the standard of membership. If a lot of men come together with a doctrine that each is obliged to maintain or be ostracized, truth cannot enter their ranks, no matter how sound their fundamental doctrine may be. The old adage that a "wise man may change his mind, a fool never," is a good one.

THE WASHINGTON MEETING OF THE AMERICAN INSTITUTE OF HOMŒOPATHY.

THE plans of the Local Committee of Arrangements, at Washington, are gradually getting into definite shape. The committee has organized with Dr. J. B. G. Custis, chairman, and Dr. William R. King, secretary, and have started out with the determination to make the Washington meeting of the Institute a greater success than the one held at Atlantic City last year, and they will hesitate at nothing legitimate to accomplish their hearts' desire. They have contracted with the three principal hotels of Washington—Willards', Ebbitt, and Riggs'—for a uniform rate of three dollars per day. The hotels are all within two to five minutes walk of the place of meeting. The headquarters of the Local Committee will be at Willard's, directly across the street from the hall where the meetings are to be held. A "Registry Book" will be provided at Willard's Hotel in which—the committee makes a special request—each member and visitor shall register themselves and their party. This register will greatly assist the Local Committee in their work of entertaining.

The opening night, Monday, June 13th, will be the banner night. The National Theatre, the best in Washington, has been secured, and the Marine Band, with Prof. Soussa at the musical helm, will be on hand. An address of welcome will be made by one of the commissioners of the District of Columbia, and the President of the Institute, Dr. Kinne, will deliver his address on this evening. Added to this, there will be addresses by some of the most famous oratorical lights assembled at Washington in the service of their country. Homœopathy has many staunch friends among the statesmen and jurists. It is proposed that President Kinne hold an informal reception on this occasion. This will add greatly to the pleasure of the meeting. It is expected that the President of the United States will be in attendance.

The arrangements for the projected trip to Mount Vernon, which is to be followed by a dinner and dance at the historic and lovely Marshall Hall, are progressing satisfactorily, and if "Uncle Jerry Rusk" will provide good weather, this unique entertainment will be a great success. Music and other pleasant entertainments, such as little dances for the young folks, will be provided at the different hotels during the evenings, so that time will not hang heavy with the visitors while the members of the Institute are attending the evening sessions.

A committee will be on hand to give information regarding public buildings, museums, halls of Congress, art galleries, etc. A reception at the White House by the President of the United States will be provided for. A post-office will be established at one of the hotels in charge of an employee of the Washington city post-office, to which office all mail for members and delegates will be sent, simplifying greatly this important matter. Ample arrangements will be made with regard to carriage rates, etc., for those who wish to visit any of the beautiful suburban points of interest, such as the Soldiers' Home, Arlington, Fort Meyer, Cabin Johns Bridge, etc., and the committee will be prepared to give any information wanted in regard to excursion rates to Luray, Old Point Comfort, or to any of the many famous battle-fields in the vicinity.

The business sessions of the Institute, as well as the larger sectional meeting, will be held in Cornwell's Hall, directly *vis-a-vis* the Hotel Willard, while most of the sectional meetings will be held in the parlors of the different hotels, all of which are within five minutes' walk of each other.

This Washington meeting of the Institute will be of the greatest

possible importance to the future of homœopathy, and fully one thousand homœopathic physicians should assemble together at the Capital on the night of the 13th of June, 1892. Congress will be in session, and an able memorial, in the form of a bill, should be prepared and presented to the Senate and House of Representatives of the United States, demanding and insisting upon homœopathic representation in the army, navy, and marine hospital service. The Committee on Legislation of the Institute will kindly take notice, and come prepared for action.

THE CARE OF THE HOMŒOPATHIC INSANE.

It is the duty of every homœopathic physician to secure from the legislature of the State in which he lives proper provision for the insane, who desire, or whose friends desire for them, the benefit of homœopathic treatment.

No State has the right to, practically, coerce its insane citizens, for whom homœopathic treatment is desired, into institutions under the care of allopathic physicians and their methods.

The patrons of homœopathy pay a large percentage of State taxes; in some States, like Pennsylvania and Ohio, nearly one-half. It is against the fundamental principles of American government for a people to pay taxes which are to be used for the exclusive benefit of a favored class at the expense of a large minority. American people, with the noted single exception of a majority of allopathic physicians, believe in the doctrine of "equal and exact justice to all and special privileges to none." While it is the duty of the State—the State being the guardian for its insane—to see that proper provision is made for the treatment of its insane, it will be irrational to expect a State to remedy the injustice done to its homœopathic citizens by not providing proper treatment for their insane, unless the advocates of homœopathy take the initiative themselves, and call the attention of its legislature to the existence of the class favoritism that is now prevalent in a large majority of the States.

In the great Commonwealth of Pennsylvania, with all its enormous wealth and abundant resources, no provision whatever is made for the care and treatment of its insane citizens wanting homœopathic treatment, while millions upon millions of dollars have been expended to provide accommodations for those using allopathic treatment. The same is true of Maryland, of Ohio, and of Illinois, Ken-

tucky, and many other States, with this *vast* difference: the homœopathic physicians of Kentucky and Illinois are hard at work, doing their best to right the wrong done their patrons, while those of Pennsylvania, Ohio, and Maryland are supinely resting, waiting for something to turn up.

To-day, if a homœopathic physician in the State of Pennsylvania, through some unfortunate circumstance, was called upon to place a loved member of his immediate family circle in an institution for the insane, he would be forced to put them in an asylum under the control of allopathic physicians, and in which he would be denied the right of personally attending even a member of his own family, let alone a patient. The State of Pennsylvania has not an institution, public or private, where the insane can receive the benefit of homœopathic treatment.

Legislatures help those who help themselves, and when a united profession will knock at the door of the legislature of their State and demand in no uncertain tone the right of the same provision for their insane that is made for the insane of the allopathic faith, they will receive a respectful hearing and a speedy grant of their just claim.

In the report of the Secretary of the Pennsylvania State Board of Health, December, 1890, which has just been published, there is given a table showing the number of persons to each physician in each county. For instance, the county of Bedford has one physician to 17,464 inhabitants, while Forest county has one physician to 208 inhabitants. This is a very wide margin, and yet neither county offers any special attraction to an M.D. seeking for a location. Philadelphia has one physician to 405 inhabitants, and Allegheny county is not far behind, with one physician to every 677 of her people. The table shows Philadelphia to have 138 women physicians, there being a total of 306 women doctors in the State of Pennsylvania. This indicates that they have come to stay. Allegheny county has 525 and Philadelphia 2090 registered physicians, thus assuring the sick and suffering public of these counties an ample medical supply in case of need. Allegheny county has 100 physicians practicing without a diploma, while Philadelphia has but 95. This is due, no doubt, to the fact that the facilities for obtaining a diploma are much greater in the latter county. There are a total of 922 physicians in the State who are practicing without a diploma, being about 10 per cent.

WHY do not the 400 homœopathic physicians of the City of Brotherly Love (?) make a demand for representation on the staff of the Philadelphia Hospital? Their patients pay nearly, or quite, one-half of the cost of maintenance of this hospital. Of course, the University of Pennsylvania will act as if she owned this municipal institution,—but she don't. Let the 400 come together and try their strength just once. They will surprise themselves, as well as somebody else. By the way, why is homœopathy not taught at the University of Pennsylvania? It is largely a State institution. It is not owned by the allopathic doctors.

DR. SARAH J. MILSOP, of Bowling Green, Ky., is doing good work in her city in advancing the movement of the Kentucky Homœopathic Medical Society to secure the establishment of an insane asylum in the State of Kentucky, where patrons of the new school can secure the benefits of homœopathic treatment. She has the active sympathy and support of the local daily papers, both in their news and editorial columns; and if the rest of the physicians in Kentucky are meeting with her success, the State will soon have the benefit of a well-equipped insane asylum under homœopathic control.

DR. JOHN B. ROBERTS, President of the Allopathic County Medical Society of Philadelphia, since he is now outspoken for *liberal* action, will, *without doubt*, advocate an impartial and equitable *single* Board Medical Examiners' bill for Pennsylvania, which will provide for the equal representation of the three schools of medicine upon said board; or, perhaps he will adopt the alternative of establishing a Medical Examiners' Board for each school of medicine. He will be expected to be consistent.

WE invite the attention of every homœopathic physician living in a State not provided with an asylum for the care of the insane under homœopathic treatment, to the vigorous editorial on page 33 of the *News and Advertiser*, from the pen of Dr. A. L. Monroe, appearing in the *Louisville Truth*, January 24, 1892, entitled "A Question of Little Pills."

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D.,

FRANK H. PRITCHARD, M.D., AND EDWARD M. GRÄMM, M.D.

CONCUSSION OF THE SPINAL CORD WITH INTRADURAL HÆMORRHAGES.—Prof. Gussenbauer, of Prague, demonstrated a case of concussion of the spinal cord before the Medical Society of Prague. A man, 32 years of age, fell from a street car upon his back. As he struck he experienced a very violent pain in his back, perceived himself lying parallel with the track, but at this moment he lost consciousness. He was brought to the writer's clinic, where he complained of violent "girdle pains" which radiated from the back into the abdomen and of a numb sensation which extended from the hypogastrium over the scrotum, thighs and, later, the legs. The movements of the legs were undisturbed when he was lying abed, but when placed upon his feet and told to attempt to walk his knees would bend and he would sink down and be unable to hold himself upon his legs. There were only a few unimportant sugillations upon his hips, hence a fracture or luxation of the vertebræ was out of question. Placed in bed, in the dorsal decubitus, the patient complained of augmented vehemence of the spinal pains and an increase of the numb sensation in the scrotum and legs. The next day the movements of the legs were greatly disturbed and the sensibility was also greatly reduced, on the right side more than on the left; the urine could not be voided with the use of the catheter and defecation was impossible. The patient was placed upon the side instead of back, and ice-bags placed upon his back, whereupon the pains immediately ceased. In three days spontaneous evacuation of the bladder was possible; the numb feeling gradually disappeared, and motility returned little by little. The patient gradually became able to make all movements with his legs, stand alone and walk with assistance. During the days immediately following the accident the reflexes were below the normal, yet later the patellar reflexes were increased. The patient was, in the beginning, without fever; in the next few days following the temperature went up a little and a slight cystitis appeared. On the bladder being washed out with a boric acid solution the cystitis and fever disappeared. The writer thinks that the patient sustained a concussion of the spinal cord, when, through vacillations in the pressure of the cerebro-spinal fluid, the circulatory disturbances in the intradural vessels led to extravasations of blood. The multiplicity of the phenomena pointed to intradural hæmorrhage, and this assumption was supported by the rapid and continuous retrogression of the symptoms. The urine was examined for urobilin with negative results, yet this was only of slight importance as one could only expect to find urobilinuria where large extravasates were undergoing absorption.—*Wiener Med. Presse*, No. 50, 1891.

DIAGNOSIS OF DISEASES OF THE GALL-BLADDER.—Dr. Rheinstein, of Berlin, has demonstrated a method of examination which permits one to recognize alterations of the gall-bladder. Generally the gall-bladder is but little palpable, as its walls are so thin, it lies so near the abdominal walls, and is surrounded on nearly all sides. When pathological changes set in it becomes more easily felt, either by increase in volume, augmented thickness of the walls, or because it is displaced. This latter state is especially observed when the liver is hypertrophied and displaced downwards, as is seen in women who have borne many children. In order to palpate the gall-bladder the abdomen should not be too distended by the intestinal contents, nor should the fatty pariculus be too well developed. The patient is placed in the dorsal position, the physician stands at the right of the patient, who should breathe quietly and with open mouth; the left hand is placed flat upon the right lumbar region of the patient, the fingers pointing towards the spinal column, the right hand is laid upon the anterior surface of the abdomen, the hand running in the direction of the middle line of the body and the ends of the fingers reaching the lower border of the ninth costal cartilage. While one supports energetically

with the left hand, with the right hand one pushes deeper and deeper with each respiratory movement. The gall-bladder becomes fixated and palpation becomes possible. If the liver be displaced downward, the left hand may be employed to fix the liver in its abnormal position, the right hand pushes the soft parts from below upwards, the tips of the fingers being placed up against the lower border of the liver. With the four fingers one searches for the gall-bladder, making counter-pressure with the thumb against the upper border of the liver. During the year the writer has been able to palpate the gall-bladder in twenty-four patients, demonstrating in four the presence of gall-stones.—*Le Bulletin Medical*, No. 89, 1891.

ELIMINATION OF THE TOXIC PRODUCTS IN TYPHOID FEVER ACCORDING TO THE VARIOUS METHODS OF TREATMENT.—Drs. Roque and Weil, of Paris, have published the results of their experimental investigation of this subject which is of the greatest practical importance. The writers have demonstrated that in cases of typhoid fever, left to themselves and without treatment, the toxic products secreted by the bacilli and the organism are partly eliminated during the course of disease. The urotoxic coefficient is double that of the normal, yet even this elimination is incomplete, and the remainder is made up during convalescence. The urinary hypertoxicity persists for four or five weeks after cessation of the fever. In cases treated with cold baths the elimination of toxic products is enormous during the course of the disease. The urotoxic coefficient becomes five or six times greater than the normal. This hypertoxicity decreases as the general symptoms become milder and the temperature falls, so that when apyrexia and convalescence set in the elimination of the toxins is at an end and the coefficient is reduced to the normal. The cold bath treatment is therefore an eliminative treatment; it is not specific, inasmuch as it does not prevent the production of toxins but assures their expulsion as soon as they are formed. On the contrary, in cases treated with antipyrine the elimination of toxins during the disease and use of the remedy is reduced to nothing; the coefficients descend nearly to the normal, while in the course of convalescence the toxic products are suddenly eliminated in mass for five or six days. Hence the writers conclude as to the injuriousness of treating this disease with antipyrine, and give the preference to the hydriatic method.—*Gazzetta degli Ospitali*, No. 80, 1891.

PARALYSIS FROM LIGHTNING.—Dr. Fimbeck, of Prague, Bohemia, finds that the consequences of lightning upon the nervous system, observed in persons struck by lightning, may be divided into direct, *i.e.*, those immediately dependent upon an affection of the nervous system, and indirect, or those proceeding from other changes which influence the nervous system. He describes a case of this latter variety. It presented itself under the clinical picture of a right-sided hemiparesis with participation of the two inferior branches of the facial nerve and of speech; indeed, the picture was that of hemiplegia, due to apoplexy in the territory of the internal capsule. The writer actually considered the condition in question of such a nature; the case also presented contractures and spastic manifestations. Another case presented sensory and motor paralysis of one extremity and is classed by the author in the first group. The sensory paralysis soon disappeared; the motor improving later. The case also presented all the characteristics of traumatic alterations of a hysterical nature. In order to study the effects of lightning upon the nervous system the writer experimented upon rabbits and frogs, and found it possible to obtain central and peripheral paralysis, in both the frog and rabbit, by means of electric discharges from Leyden jars. In the former the electric stimulability diminished considerably. The early disappearance of the sensory paralysis compared with the motor, is explained by the fact that lightning affects pre-eminently the muscles and not the peripheral nerves.—*Prager Medicin Wochenschr*, No. 13, 1891.

THE ÆTIOLOGY OF GASTRIC DYSPEPSIA.—Drs. Mathieu and Remond have examined fifty-four cases of gastric dyspepsia and have arrived at the following conclusions:

1. Emotional as well as physical shocks, neurasthenia, chlorosis, and alcoholism may all give rise to various forms of gastric dyspepsia; dyspeptic states therefore cannot be exclusively classed according to their ætiology.

2. Neuropathic states have a capital importance in the causation of various forms of dyspepsia; yet one can not attribute it to them entirely.

The dyspepsia of alcoholists is not always due to gastritis and even if it be present it is not always of chief importance.—*Le Bulletin Medical*, No. 101, 1891.

EPILEPTIFORM ATTACKS DUE TO THE PRESENCE OF TENIA.—Dr. Martha has made a study of this subject. Epileptiform spasms in persons suffering from tænia are of great rarity. The writer has collected twenty-two cases. According to him, the attack is not the classic epileptic spasm, but merely pseudo epileptic, as expulsion of the parasite causes the fits to cease, yet the characteristics of these pseudo-epileptic attacks differ but little from those of idiopathic epilepsy. The attack has not the characteristic brusqueness of epilepsy, the patient generally finds time to prepare himself for the fall, to throw himself upon a bed, to cry for help and serious falls and injuries are exceptional. The initial cry, biting of the tongue, foaming at the mouth, are constant symptoms and of no diagnostic importance. The convulsive and comatose periods are of longer duration than in idiopathic epilepsy. They have a certain tendency to become periodic, to appear every month at the same time or every year at the same season. The male sex is more frequently attacked than the female, and nervous, hereditary or personal antecedents play no part in these convulsive manifestations. The predominance of convulsive movements upon one side of the body is not so frequent as in real epilepsy.—*Le Bulletin Medical*, No. 103, 1891.

GASTRO-INTESTINAL HÆMORRHAGES.—Dr. Hampeln has made a study of this subject. If one leave aside the anæmia caused by parasites one finds a whole series of essential anæmias, of which the principal representative is chlorosis. Even in chlorosis it is doubtful whether the condition in question be not due to latent visceral hæmorrhages, pseudo-latent, gastro-intestinal or gastric hæmorrhages. If more than 500 c.cm. of blood be poured into the stomach it only gives a blackish coloration to the fæces, therefore all quantities below this are passed unobserved. Rorezynski found, in twenty patients with gastric ulcer, greater or less quantities of blood in the stomach. This could be syphoned off, while examination of the fæces revealed nothing. These latent gastric and gastro-intestinal hæmorrhages are chiefly due, if helminthiasis be excluded, to the presence of a round ulcer. Under pseudo-latent gastro-intestinal hæmorrhages the writer would have classed those hæmorrhages that do not offer themselves directly to the observation of the physician and which, hence, are easily neglected. In such cases one observes only now and then a dark discoloration of the fæces. One should not forget that bismuth and iron will blacken the fæces. In gastric hæmorrhage—hæmatemesis—it will be difficult to distinguish, if one depend upon the patient's story, whether the condition be hæmatemesis or hæmoptœ. If he spit blood the following day it is hæmoptœ, if the contrary, hæmatemesis. Gastric hæmorrhages originate most frequently in a round ulcer; second in importance is a carcinoma. Small erosions of the stomachal mucous membrane may sometimes give rise to furious and fatal hæmatemesis. The writer has observed such a case. He would also regard capillary hæmorrhages from the gastric mucous membrane as the cause of a large number of chronic anæmias and even chlorosis.—*Gazzetta degli Ospitali*, No. 84, 1891.

SYPHILIS OF THE PLEURA.—Dr. Wladimir Nikulin, of Moscow, Russia, has made a study of this subject in the clinical material of Professor Sacharjin. From his observations he sets up three forms: 1. Syphilitic pleuritis, originating in the lung and passing secondarily to the pleura. 2. Syphilis of the pleura proceeding primarily from the bony walls of the thorax. 3. Primary syphilis of the pleura. The term, primary syphilis, is, if exactly taken, not correct, as in reality it is but a localization in the pleura of an already existing syphilitic infection. These forms of pleuritis, the manifestations of constitutional syphilis, and making their appearance in the secondary as well as tertiary stage, in spite of the certainty with which Nikulin and Talamon speak (see *Médecine Moderne*, No. 38, 1891), are still surrounded with much mystery. Curing the disease with the iodides or some mercurial preparation is no proof of their syphilitic nature, and a disease like pleuritis will, within a given time, disappear spontaneously without treatment. (See HAHN-EMANNIAN MONTHLY, January, 1892).—*Pleuritis During the Eruptive Stage of Syphilis*.—*Berliner Klin. Wochenschr.*, No. 40, 1891.

PULSATING EXOPHTHALMOS.—Dr. Israel presented to the Medical Society of Berlin a patient suffering from a rare form of exophthalmos, namely, the pulsating variety, due to a retrobulbar cavernous angioma which implicated the right eye. Besides protrusion of the eyeball there was a slight ptosis of the upper eyelid, which was covered with varicosities of a bluish color. The patient was hypermetropic and suffered from cutaneous malformations.—*Le Bulletin Medical*, No. 103, 1891.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

TREATMENT OF IRREDUCIBLE INTUSSUSCEPTION OF THE BOWELS.—A. E. Barker, London, suggests a modification in operative technique which he thinks will be of value in intussusceptions which cannot be reached from below, and which are too tightly strangulated to reduce with safety. By this method the necessity of forming an artificial anus is done away with on the one hand, and on the other, that of resecting the whole mass of damaged bowel and uniting the ends.

The operation is performed as follows: The *intussusceptum* and *intussuscipiens* are united at the point where the former enters the latter, by a fine silk suture of the serous and muscular coats of the intestine and the mesentery. The *intussuscipiens* is opened by a longitudinal, two inch incision of its free margin. The *intussusceptum* is drawn out through this opening and amputated close to its upper end; or, if too long to be first drawn out, it is cut across *in situ*. A few silk sutures are then passed through all the walls of the stump; these serve to unite the serous edges and to control the hæmorrhage which otherwise will be quite free from the mesenteric attachment. The stump is now cleaned, dried, dusted with iodoform, and replaced; and the longitudinal incision closed by a continuous suture. Including opening and closing the abdomen, the operation can be performed in less than half an hour. The writer has operated two cases by this method which terminated fatally, but the result he attributes to the hopeless condition of the patient; while post-mortem examination showed that the sutured surfaces had not given way.—*London Lancet*.

THE RÔLE OF THE COMPRESSOR URETHRÆ MUSCLE IN RELATION TO ACUTE ANTERIOR AND POSTERIOR URETHRITIS.—Ernest Finger, Vienna, strongly opposes the commonly accepted view, that the compressor urethræ muscle is the barrier which prevents the extension of an acute, anterior urethritis beyond that point, and lays much stress upon the fact that a closer study of the urethra must be made to discover the actual cause. To do this he divides it into five portions, each of which is characterized as follows:

1. Pendulous and bulbous portion which has a rich supply of follicles and lacunæ, as well as a good vascular supply. (These portions are in front of the compressor urethræ.)
2. Membranous portion (behind the compressor urethræ) which is poorly supplied with lacunæ, follicles, and bloodvessels.
3. Prostatic portion which is again richly supplied with vessels, lacunæ, and follicles.
4. Ostium internum urethræ which has few follicles and lacunæ.
5. Mucous membrane of the bladder which possesses a good supply of follicles, lacunæ, and vessels especially at the fundus and trigone.

It can now be readily seen how a recent urethritis commencing in the anterior portion of the urethra, will gradually extend over the mucous membrane from lacuna to lacuna and vascular follicle to follicle until it reaches the membranous portion, which, as shown above, being poorly supplied with follicles and lacunæ will act as a formidable barrier to any further extension.

In case the inflammatory process should extend over the membranous portion (as a result of improper treatment or otherwise), thereby setting up a posterior urethritis, the same structural arrangement which exists in the membranous portion also being found at the mouth of the bladder, will tend to prevent the extension any further, thus guarding against a cystitis.—*Internationales Centralblatt für die Harn und Sexual Organe*.

RECENT MODIFICATIONS IN THE TECHNIQUE OF ENTEROTOMY AND COLOTOMY.—1. Robert Jones (Liverpool), proposes the following modification to the ordinary operation for artificial anus:

After the bowel is stitched to the parietes, if it becomes necessary to relieve obstruction or distension before safe adhesions have taken place, a slit is made in the intestine, a rubber tube is introduced, and the bowel wall tied around it. Gas and even liquid feces can thus be evacuated without contaminating the wound. In two cases of enterotomy and one of inguinal colotomy the urgent symptoms were relieved by this procedure.

2. A. W. Mayo Robson (Leeds, England), has accomplished the same result by means of a large trocar, to which he attaches a piece of drainage-tubing; through this the bowel contents are carried into a vessel containing an antiseptic solution placed at the side of the patient. The tubing can be attached to the end of the canula after withdrawing the trocar, or the end can be closed and the canula made with an exit tube at the side, as in the Dieulafoy aspirator, to which the tube is fitted. The writer has employed this modification in a number of cases with success.

3. H. A. Reeves (London), has practiced a "simplified" colotomy, or "sigmoidostomy," without untoward results:

Colotomy is begun in the usual manner drawing down the bowel until it is taut. A piece of elastic catheter, properly sterilized, is passed through the meso-colon close to its point of attachment to the intestine and padded outside the abdominal wall with lint; the wound is packed with an absorbent dressing and *the parietics are not stitched to the bowel*. At the end of from two to seven days the intestine is opened. The spur is well marked and the time of operation is much lessened. The writer claims "absolute novelty" for this method. The suspension by a rod is the same as that recommended by Maydl [*Centralblatt für Chirurgie*, No. 24, 1888], and has been used by us in several cases; so too the packing instead of suture when urgency called for it.—Eds.)

THE CEREBRAL ATROPHIES OF CHILDHOOD.—M. Allen Starr (New York) after reviewing the clinical types of cerebral atrophy in childhood, the pathological conditions producing them, and the results of craniotomy, concludes that

1. Hemiplegia, sensory defects, and imbecility in children, with or without epilepsy, are incurable by medical treatment. Any legitimate means to prevent a life of invalidism are justifiable.

2. These conditions may be produced either by gross defects and atrophies of the brain, or by an arrest of development in the cerebral cells without any change which is apparent to the naked eye.

3. The exact pathological condition cannot at present be determined without an exploratory operation.

4. Such operations are dangerous (eight deaths in twenty-three cases), but with care in opening the dura, and when quickly performed they are much less so.

5. Operations will do no good when manifest atrophies are present; they may be beneficial when the condition is one of arrested development of cerebral tissue; still more so when clots, cysts, or tumors are removed. In a micro-cephalic skull from early union of the sutures, the increased space given the brain appears to stimulate its growth and development.

6. Craniotomy will often reduce the number and modify the character of epileptic attacks. If the opening in the skull remains covered only by the soft tissues, it appears to act as a safety-valve, allowing intra-cranial changes to take place without producing pressure.

7. Hemiplegia, aphasia, athetosis and sensory defects have been relieved by operation; it is impossible to predict to what extent imbecility may be relieved.

8. Reports should be made in full; they should not be made within six months of the time of operation; conclusions, unless reached from long observation, are not reliable.—*Medical Record*.

STUDY OF THE PRINCIPAL METHODS OF PROVOKING PREMATURE LABOR.—By Dr. Oui, Chief of the Obstetrical Clinic of the Faculty of Bordeaux.—Mention is made of the different methods of Krause, Barnes, Tarnier's and Champetier's bags. Barnes's fiddle-shaped bag is adversely criticized. A number of cases are related where the operation was necessary for deformed pelvis and other difficulties, the results being given in the different methods not only in the rapidity with which the pains are produced, but also the rapidity of the labors. He sums up as follows:

1. The sound of Krause should be absolutely rejected except in case of absolute necessity. The labor resulting from it being too slow and the mortality of the children therefore in greater proportion than with other proceedings.

2. In primipara, or even in multipara, when the cervix is rigid, recourse should be had first to Tarnier's bag, following with the bag of Champetier, so soon as the cervix is sufficiently opened.

3. In any case when the dilatability of the neck is sufficient, Champetier's bag is indicated from the first.

4. The more pronounced the necessity for a rapid labor so much the clearer is the indication for Champetier's bag.—*Annales de Gynécologie*, January, 1892.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

CARE OF THE BLADDER BEFORE AND AFTER LABOR.—The true cause of vesical irritation in displacement is not pressure upon the fundus of the bladder, but traction upon its neck. This is the explanation of this phenomenon in pregnancy. Hæmorrhoids, or fissure of the anus, a tender ovary, a severe erosion of the cervix—all these are recognized as ætiological factors in vesical tenesmus, especially in the neurotic subject during pregnancy, in connection with ischuria during parturition. Olshausen calls attention to the bend in the urethra caused by the oblique position of the head. Schwarz denies that the bladder is unable to contract firmly and ascribes the ischuria partly to the œdema of the urethral and peri-urethral tissues and partly to paralysis of the sphincter vesicæ, of nervous origin. In consequence of delay in the second stage, evacuation of the bladder is prevented from purely mechanical obstruction. The scientific study of ischuria during the puerperium has been much neglected in this country. It has been explained loosely as due to paralysis of the muscular wall, though Winckel positively denies this. Schröder, who is followed by the text-books, attributed it to the increased cavity of the bladder following the sudden reduction in size of the uterine tumors. Schwarz thinks diminished intra-abdominal pressure is the principal ætiological factor, as the same ischuria is seen after the removal of ascitic fluid or abdominal tumors. In my experience it is usually due to hyper-distension of the bladder and paralysis of the sphincter from prolonged pressure of the head, in short, to the neglect of the catheter during labor. Any abnormal condition of the urine during pregnancy is to be corrected by proper diet (especially milk) and appropriate remedies. I have relieved many patients with irritation of the neck of the bladder by means of the old-fashioned flaxseed tea and cream of tartar mixture.—Dr. H. C. Coe, *American Journal of Obstetrics*, July, 1891.

VAGINAL HYSTERECTOMY.—Although a year ago Dr. Coe took a decided stand against vaginal hysterectomy, except in cases in which the cancer was confined to the corpus uteri, the results of others and a study of the technique of the operation had altered his views. In ten cases of Dr. Krug's which he examined, the results were perfectly satisfactory. The patients were in perfect health, presenting no signs of recurrence, and without that prolapse of the vaginal wall or difficulty of the bladder which frequently followed.—*American Journal of Obstetrics*, July, 1891.

ALEXANDER'S OPERATION in several instances has been followed by great pain and pulling in the scar, so that the suffering in the last state has been as bad as at first.—Dr. M. D. Mann, *The Journal of Gynecology*, July, 1891.

DR. MANN says that as nearly all pelvic inflammation begins in the uterus and tubes, their involvement is a necessary complication.—*The Journal of Gynecology*, July, 1891.

CHRONIC PELVIC ABSCESS is almost a myth. It may exist as a result of tuberculosis, or be dependent on disease of the lymphatic glands. Cellulitis I think exists only as an acute process following sepsis or labor and then only occasionally.—Dr. W. H. Parish, *Annals of Gynecology and Pædiatry*, July, 1891.

REMOVAL OF THE PRODUCTS OF PELVIC INFLAMMATION.—Dr. B. F. Baer says that cases with the products of inflammation in the pelvis with depraved nutrition, a broken down nervous system, and disordered digestion require careful consideration. He has operated on this class of cases after prolonged palliative treatment had failed to benefit, and has been sorry that he did so, and has become very wary of them. Removal of ovaries as a cure for a broken nervous system is of doubtful utility. Some years ago chronic pelvic abscesses were met with, but since we have learned to operate early, the true pathology has been found to originate in disease of the tubes or ovaries, followed by peritonitis and not cellulitis, except as a secondary or minor complication.—*Annals of Gynecology and Pædiatry*, July, 1891.

UTERINE SARCOMA.—Terillon, of Paris, divides uterine sarcoma into two principal divisions, the first which springs from the mucous membrane and the second

which springs from the muscular layer. The first is marked by extensive hypertrophy of the mucous membrane (generally leaving free the cervical portion) with very vascular papillæ and is generally accompanied with hydrorrhœa which often contains epithelial debris. Under the second heading, interstitial sarcoma, he makes two divisions. In the first is involved the muscular layer which becomes often enormously enlarged, sometimes 19 kilograms with an uterine cavity of 12 to 15 cent. This variety often involves the ligaments and the whole mass becomes like a solid fibroma. In the second division the tumors are circumscribed, whether seated on the surface or in the muscular layer. The serous covering becomes more and more pushed forward until finally a pedicle is formed. This is the most usual form, and there are often found several tumors in varying stages of development. In this form cysts are often formed, giving rise to the so-called cystic-sarcoma. A symptom of great diagnostic value is the rapid growth of the tumors and also the consistency which gives almost an impression of fluctuation. The age also, as the period most liable is between 30 to 50, though sarcoma of the ovary and other parts occurs as early as from 15 to 25. As to surgical treatment of uterine sarcoma, the removal of the tumor through the vagina is possible only in the first stages, while the uterus is still small, but the cases seldom present themselves in this stage, and generally supra-vaginal hysterectomy must be performed. Intrauterine sarcoma which springs from the mucous membrane, can be treated to advantage with dilatation of the cervix, curretting and cauterizing with chloride of zinc or liquor ferri, which arrests the hæmorrhage and strengthens the patient. From time to time a repetition of the treatment is of benefit. Notwithstanding this, there is generally a local or general return from a few months to two years after operation. Martin seemed to think that the infection was held in check to a certain degree, by the pedicle and that the deadly septicæmia was only hastened by operation.—*Centralblatt für Gynäkologie*, September, 1891.

LOCAL ANÆSTHESIA MIXTURES FOR SMALL OPERATIONS.—Dobisch used the following mixture as a spray to produce local anæsthesia for minor operations:

Menthol,	.	.	.	.	.	.	.	.	p. 1.
Sulphuric ether,	.	.	.	.	.	.	.	.	p. 15.
Chloroform,	.	.	.	.	.	.	.	.	p. 100.

Anæsthesia is complete, profound, and lasts two to six minutes.—*Journal of Gynecology*, September, 1891.

VOMITING OF PREGNANCY.—The following is recommended for vomiting of pregnancy:

Menthol,	.	.	.	.	.	gm. 1 (grs. xv.).
Alcohol,	.	.	.	.	.	" 20 (fl. dme. v.).
Simple syrup,	.	.	.	.	.	" 30 (fl. oz. i.).

Sig.—One teaspoonful every hour.—*Journal of Gynecology*, September, 1891.

CERTAIN OPERATIONS DESIGNED TO PRESERVE THE UTERINE APPENDAGES.—In closing a paper with the above heading, Dr. W. M. Polk presents the following as the salient points:

1. In chronic disease of the appendages the incision should be in the nature of "exploratory incisions."
2. The question of removal should be, in the main, left for determination after the organs have been exposed.
3. That the condition of the ovary should be the chief factor in determining the question of procedure.
4. That, if need be, this may be determined by exploratory incisions of the ovary.
5. That, if the ovary contains pus it and the associated tube should be removed, it being the rule that whenever an ovary is removed the tube must accompany it.
6. That if the tube contains pus, the ovary being free from pus or disseminated cystic degeneration, the operator is at liberty to recommend either the removal of both organs or else the partial amputation of the tube, leaving the ovary, and that the same rule apply in cases of hydro-salpinx and hæmato-salpinx.
7. That cysts of the ovary do not indicate removal, provided they are not general throughout the organ and can be enucleated—hæmatoma of the ovary a possible exception.
8. Ovaries enlarged from congestion, as in misplacements, need not be removed.

9. Tubes with open infundibula, even though adherent and affected with parenchymatous inflammation and endo-salpingitis, do not demand removal, excepting when one opens into a pus-cavity.

10. A tube whose outer end is closed may be opened, cleansed, and its inner and outer coats coaptated, and then be returned to the abdominal cavity; provided it does not contain pus, and, possibly, old blood.

11. Adhesions do not demand the removal of the tubes and ovaries, unless they be so dense that in breaking them the appendages are seriously injured. This presupposes that the appendages in themselves are not sufficiently diseased to demand removal.—*American Journal of Obstetrics*, September, 1891.

THE TREATMENT OF NON-MALIGNANT RECTAL STRICTURES.—The present status of the treatment of cicatricial rectal strictures is approximately as follows:

1. When the stricture consists of a thin, valve-like fold, gradual dilatation.

2. When the cicatrix is small, but dense, incision, with or without rapid dilatation, are sometimes practical when gradual dilatation has failed (internal proctotomy of Gosselin).

3. When the stricture is thick and dense, and is attended by some ulceration, or by fistulae, external incision through the stricture.

4. In cases complicated by extensive ulceration and burrowing of pus, and especially in those demanding speedy and certain relief, colotomy.—W. Van Hook, M.D., *American Journal of Obstetrics*, September, 1891.

AUTOMATIC MENSTRUAL GLANDS.—In a paper read before the Gynecological Society of Chicago, Dr. F. B. Robison advances a new theory of menstruation. The prominent points in the theory are:

1. *The proof of the existence of the ganglia in the tubes and uterus from analogy.* All hollow viscera have ganglia in their walls. Histologists have long known that many viscera possess ganglia which have automatic power.

b. A large number of experiments on the intestines of animals have convinced me distinctly that the intestines are endowed with automatic ganglia in a similar manner to the heart.

c. The same statement can be made relative to the bladder. It is supplied with two kinds of nerves, the cerebro-spinal and the sympathetic.

d. The analogies of the heart, intestine and bladder, are quite apparent, and can be reasonably carried to the uterus and tubes. They are all hollow organs. The tubes and uterus are no exception to the other abdominal viscera.

e. The fallopian tube is simply a continuation of the muscular walls of the uterus, but not of the endometrium. The endometrium seems to be a temporary gland, whose duration of active life is the menstrual period. The analogy of the hollow tube of the intestine or heart is very close.

2. *The proof of the existence of the ganglia in the tubes from direct observation and experiment.*

The change in the tubes at puberty are as follows:

a. It assumes rhythmic movements.

b. Its muscular wall increases.

c. Its vascularity is much increased.

d. It straightens out and loses its corkscrew or spiral shape of fetal life.

e. Its epithelium becomes dilated.

f. Its great activity appears mainly at the abdominal end.

3. *The microscope or sometimes a large lens* will demonstrate the existence of ganglia on the plexus of nerves going to the uterus and tubes. Ovaries are extirpated and tubal motion continues. However, the destruction of a part of a connected complex organ soon destroys the nice balance, and nourishment of the ganglia would in time deteriorate, and then insufficient nerve vitality with lack of ganglionic harmony would fail in starting and maintaining a menstrual rhythm. Finally, the tubes and most of the uterus being removed, menstruation will nearly always stop. The ovary left without a tube, would not sustain menstruation.—*American Journal of Obstetrics*, September, 1891.

METHYLEN BLUE AND SUPPURATION.—Whenever there is a suspicion of pus, gr. jss. of Merk's methylen blue in capsules administered three times per day absolutely prevents cystitis and improves the constitutional taint due to absorption of pus.—Dr. F. Von Raitz, in *Archives of Gynecology*, November, 1891.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

SOME ABNORMAL EYE SYMPTOMS AS A DIAGNOSTIC AID TO OTHER DISEASES.—Attention to the eye symptoms will often result in a physician looking for other signs, and this may lead to the detection of a state of affairs hitherto unsuspected.

(Edema of the lids is often the first thing noticed in the examination of a patient. This may mean conjunctivitis, a premonitory symptom of coryza, the simple fevers, hay fever, arsenical poisoning, some lesion of the heart, lungs, or kidneys. When administering arsenic this oedema is a valuable sign as showing that the drug is being given in excess of the bodily powers to eliminate.

Styes show an anæmic or strumous condition, or derangement of the digestive apparatus or organs of reproduction. They are also found in certain forms of eye-strain. The same conditions that produce styes may cause that chronic inflamed condition of the lids termed blepharitis marginalis.

Ptosis, while due to inflammation of the lids, tumors, or erysipelas, is also frequently indicative of brain lesion, with paralysis of the third nerve.

Blepharospasm may occur during mental excitement or an epileptic seizure; it may also be found in chorea or hysteria.

Marked protrusion of one eye would probably mean a new growth in the orbit; of both eyes, exophthalmic goitre. Inability to move the eye outward would lead one to suspect paralysis of the sixth nerve. Paralysis of the sixth nerve, with hemiplegia of the opposite side, points to a lesion at the pons varolii—usually on the same side as the eye affected.

The fixed stare of some forms of hysteria and insanity are well known; also the rolling of the eyes during convulsions and approaching dissolution.

The cornea and conjunctiva are often red and injected, or have a peculiar appearance. In diphtheria the membrane sometimes forms here, though rarely. The reddish appearance in hay fever, scarlet fever, measles, and from an overdose of the iodides is familiar to all of us. Phlyctenules show a depraved condition of the system and improper diet. Painless ulcers on the cornea generally indicate a lesion of the fifth nerve. In jaundice the conjunctiva becomes of a brownish hue; in Addison's disease it looks lustreless and dark-colored.

Arcus senilis in the young or middle-aged is often an accompaniment of fatty heart or fatty degeneration of other organs.

Nystagmus—that rapid involuntary movement of the eyes—is a sign of third- or sixth-nerve paralysis, or a premonitory symptom of disseminated sclerosis. It is also found where the eyes are of unequal refraction.

The pupil should be carefully watched. It is dilated in hysteria, hypochondria, lead-poisoning, hydrocephalus, paralysis of the third nerve, reflex irritation from seat-worms, and after the administration of large doses of the following drugs: Aconite, salicylic acid, strychnia, belladonna, cannabis indica, conium, duboisia, digitalis, ergot, hyoscyamus, quinine, lobelia, pulsatilla, veratrum viride, santonin, stramonium, nitrite of amyl and gelsemium. The dilated pupil during chloroform narcosis is a danger signal.

The pupil is contracted during all early stages of brain disease, cholera, intracranial tumors, cerebral apoplexy, and all lesions of the brain or spinal cord above the dorsal vertebræ. Opium, jaborandi, tobacco, physostigma, carbolic acid, calabar bean and chloral hydrate all contract the pupil when given in large doses. The pupils being of unequal size is almost certain to be a precursory sign of insanity. If the pupil does not react properly, and the iris is slightly altered in color, there is an iritis of syphilitic, rheumatic, or gouty origin. Post-partum, or any other severe hæmorrhage, may be followed in from two to fifteen days by loss of eyesight, which is not usually regained.

Subjective Symptoms.—The patient complaining of the eyes being easily fatigued may be the first symptom calling your attention to a general anæmic condition. If complaint is made of only seeing half an object, look for beginning paralysis with a lesion or tumor of the brain.

In many cases of parametritis and pelvic cellulitis the eyes are easily fatigued, accompanied by orbital pain and more or less sensitiveness to artificial light.

In spinal disease the patient is apt to have diplopia, photophobia, muscæ volitantes and undue retentation of after images.

Loss of accommodation is often present in pathological irritation of the dental branch of the trigeminus, a spur on the nasal septum, intestinal irritation from worms, diseases of the stomach, liver, or intestines, and during convalescence from diphtheria.—*Medical Record*, December 19, 1891.

CHLORINE-WATER AS AN OPHTHALMOLOGIC DISINFECTANT.—Prof. H. Schmidt-Rimpler, of Göttingen, after a large number of experiments—bacteriological, animal, and human—made with chlorine-water, salicylic acid, carbolic acid, thymol, potassium, permanganate, quinine, etc., has come to the conclusion that chlorine-water is the most powerful disinfectant for ophthalmologic use. The customary 1-5000 solution of corrosive sublimate, the strongest that is borne well by the eye, he regards as much weaker in disinfecting power than chlorine-water, which, for the last year and a half, has been the sole disinfectant employed by him in all operations upon the eye. These latter included, according to the *Deutsche Med. Woch.*, 125 cataract extractions and 375 major operations. In the former, healing always progressed smoothly, and never did serous iritis supervene; the latter,—among which, naturally, there were many plastic operations,—all healed by primary intention. Prolonged opacity of the cornea, such as comparatively follows the use of corrosive sublimate in cataract extraction, if cocaine be previously instilled into the eye, was never observed with chlorine-water; nor was any extensive superficial opacity of the cornea, shedding of epithelium, or eversion of the lid on closing the eye, produced by the use of chlorine-water in cataract operations.

It was proved that chlorine-water does not irritate the wounds or the conjunctiva. On the contrary, the latter discharges much less than after sublimate irrigations. Besides, the chlorine-water, which was always employed unmixed, exerted a certain hæmostatic influence. As for its proneness to decompose, it is insignificant if the preparation be kept in dark, glass-stoppered bottles, and protected from sunlight and air.

This preparation was also used with very satisfactory results in purulent corneal affections, particularly *ulcus serpens* (as a wash, several times daily).—*Merck's Bulletin*, January, 1892.

THE TREATMENT OF SCROFULOUS INFLAMMATIONS OF THE CORNEA AND CORNEAL ULCERS WITH IODOL.—In the *Centraltbl. f. prakt. Augenheilk.*, October, 1891, Thomalla describes the excellent results which he has obtained with iodol in the treatment of the diseases mentioned in the title. He has employed this drug in cases where the corneal ulceration developed from a phlyctenule, and the conjunctiva was so swollen that it was well-nigh impossible to separate the lids; in corneal ulcers whose floor and borders possessed a grayish-yellow or cheesy infiltration and which were unassociated with the development of reparative vessels; and, finally, in those ulcers in which reparative panus had arisen. Even in severe cases, after eight days, distinct improvement was visible, and cicatrization of the ulcer was secured in about three weeks.

No doubt iodol acts as calomel does in an antiseptic and stimulating manner, but has the additional advantage that under its influence the purulent secretions are diminished. For this reason the author suggests that it might be useful in the various types of blenorrhœa.

Thomalla's results have been obtained not alone in cases which were at the same time under the influence of general medication, but also when the drug was used without such assistance. He is of the opinion that finely powdered iodol is suited to a great number of inflammatory corneal diseases, and quite equal in efficiency to calomel, possessing the great advantage that it may be employed when the patient is at the same time taking some form of iodine, under which circumstances the mild chloride of mercury is distinctly contraindicated.

APHONIA.—Place a flat sponge electrode at back of neck, and laryngeal electrode upon glottis, following down the tongue closely. With fine, smooth faradic current of moderate (such as is easily borne) strength, make and break circuit half a dozen times rapidly. Repeat two or three times, and eccentric cases are usually cured.—*The Times and Register*, January, 9, 1892.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., AND FRANK H. PRITCHARD, M.D.

TREATMENT OF MIGRAINE.—Dr. Marc Jousset, of Paris, France, divides this affection into three varieties: essential migraine, ophthalmic migraine and ophthalmoplegic migraine.

Essential migraine.—*Digitalis purpurea*.—In persons poisoned with this drug one observes terrific frontal headache, associated with vertigo, scintillations of light before the eyes and profuse bilious vomiting. The writer has often succeeded with this remedy; he administered it in the mother tincture, one to two drops a day.

Nux vomica.—Hemicrania with violent vomiting, the pain extends to the occipital region; it begins in the morning on awakening and becomes worse during the day. Walking and mental effort aggravate the *nux vomica* patient, who generally is of a spare build, constipated, has, possibly, hæmorrhoids, and is of sedentary habits. Dr. Clarke recommends the first (dec.) dilution. The writer employs from the 12th to the 30th.

Sanguinaria canadensis.—This drug is indicated when the pain commences in the occiput to pass forward to the forehead and eye, principally the right, a sensation as if the head would burst, chilliness and bilious vomiting. Amelioration by darkness, sleep and lying down. It is chiefly efficacious in women when the menses are profuse. In France from the 12th to the 30th dilution is used. Dr. Clarke recommends the first.

Iris versicolor.—Pain in the right side of the head, with lancinating pains in the temples, constrictive sensation, nausea, bilious vomiting and great depression. Dose, the same as of *sanguinaria*.

Calcarea carbonica.—This is a very ancient remedy for migraine. It is indicated when the migraine is accompanied by nausea, *eructations* and an icy coldness of the head, which commences in the morning, aggravation from walking and intellectual effort (comp. *nux vom.*). Dose, 12th to 30th. Dr. Clarke employs the acetate—*calcarea acetica* 2x with the same indications.

Pulsatilla.—This drug is of value in migraine most violent in the evening, with extension of pain to the eye and painful tension of the scalp; amelioration in the open air.

Natrum muriaticum.—Indicated in very painful migraine, beginning in the morning in bed, worse from walking and mental effort. Better from walking slowly and on lying down.

Stannum.—This remedy is recommended by Dr. R. Hughes when the pain grows progressively worse, to become excessive, heat of the head, with general coldness.

Sepia.—This drug is spoken highly of by Dr. R. Hughes as of value when the migraine has existed for years in women with profuse leucorrhœa. The pain is situated above the eyebrows and occiput, it is aggravated in the open air, is most intense in the morning and is accompanied by rushes of blood to the head.

Cocculus.—Indicated when the pain is intense, pulsative, increasing on eating and in the open air and of special value when the migraine is associated with vertigo and nausea similar to that of seasickness.

Kali carbonicum.—When the pain is very intense, tearing, with bilious or acid vomiting; the pains radiate into the back of the neck and are accompanied by intolerance of light.

Dr. Clarke praises *lachesis* in hemicrania during the menopause with pallor of the face, and *bryonia* for right-sided migraine with bilious vomiting.

Hydrastis canadensis.—This was used successfully by the writer, in the case of a

young girl of 13 years who suffered from repeated crises of violent migraine, together with chronic coryza and adenoid tumors of the nasal pharynx. As the parents feared an operation for the removal of the adenoid growths the hydrastis was given, 5 drops a day, after the recommendation of the English physician, Dr. Cooper. The operation became necessary later, yet the hemicrania rapidly disappeared under its influence. Allen's *Encyclopædia* gives: frontal headache, in the morning on rising, ameliorated on going into the open air; painful pulsations in the temples, better in the open air and on pressure.

In migraine consecutive to anuria *glonoine* and *digitalis* served the writer well in a case in a child.

Dr. Piedvache regards *staphysagria* as one of the most important remedies in migraine.

Dr. Simon, Jr., considers *arsenicum* a valuable remedy in periodic migraine.

Dr. Compagnon prescribes *buxus* (6, 12 and 30). He records the case of a country curé who never suffered from headache, yet invariably was seized with migraine when near the branches of this tree—the box tree.

The remedy chosen should be administered four to six days after an attack, then leave it off for three or four days, to continue again for a longer or shorter period, according to the results obtained.

Treatment of the Crisis—The most energetic palliative treatment is certainly that with *antipyrine* in doses of 7 to 15 grammes, in two doses, with intervals of 15 minutes. Unfortunately, patients soon accustom themselves to its action and it has caused an urticaria-like eruption, which itches excessively; this appears, as a rule, immediately after its administration. It may produce in some persons vertigo and weakness, so as to force one to lie down. It is merely an empiric remedy; nevertheless some recently published fragments of *materia medica* would lead one to think that it acts according to the law of similars.

Dr. Piedvache reports the case of a diabetic, who took 4 grammes—60 grains—per day to cause the sugar to disappear from his urine. On the third day he was obliged to interrupt treatment as he was seized with intense migraine, associated nausea and vomiting, beginning at 4 to 6 in the morning; every time that he recommenced treatment with antipyrine, the hemicrania would come on.

Caffeine 1x, frequently is used to diminish the pains of migraine. Three grains may be given every half hour. Its action is certainly homœopathic.

If the crisis is very intense and resists all treatment, 2 to 4 drops of a 1:50 solution of *morphine* may be given subcutaneously and with excellent results. The writer claims *morphine* to act according to the law of similars, as he has noticed that after an injection of morphine for hepatic colic the patient would suffer from a well characterized hemicrania. Besides these energetically acting remedies one may have recourse to *glonoine*, *aconite*, *belladonna*, *tobacco*, *veratrum*, or *kali carbonicum* according to the character of the attack. The following are the characteristics:

Glonoine.—Face congested, violent beating in the head, increased by the slightest movement. Sensation as if the head would burst. Dose: 3x-1x one drop every half hour.

Aconite.—Sensation of compression of the head, constrictive sensation in the forehead, congestion of the head. Dose: mother tincture, 1-3 drops every half hour. Dr. Clarke recommends this remedy when the face is pale, livid and anxious. Both of these pictures are found in the pathogenesisy.

Belladonna.—Face red; head hot; sensation of burning in the eye-balls, made worse by light, motion, or the least noise. Disturbances of vision, transitory deafness and luminous scintillations. Dose: 1x-3x, one drop every half hour.

Nicotiana tabacum.—Violent pain, pulsation in the temples, vertigo and vomiting. Dose: 1x trituration.

Veratrum album.—Atrocious headache, with cold sweat and tendency to syncope; stiffness of the muscles of the neck. Dose: one drop of the tincture every half hour.

Dr. Clarke employs *kali carbonicum*, 6x, when the pain is intense, the photophobia is severe and there are visual disturbances.

The continuous current sometimes exercises a sedative action upon the pain.

Ophthalmic Migraine—*Belladonna*.—This remedy has given the writer the best results as it contains the greatest number of corresponding symptoms. Among its provings, for example, burning sensation in the eyes, scintillations and *muscæ volantes*, as well as paralytic phenomena. The twelfth dilution (dec.) apparently gave the writer the best results. The following drugs will be found indicated in special conditions:

Digitalis.—Transitory deafness, amblyopia, scintillations before the eyes.

Iris versicolor.—Spot before the eye affected.

Phosphorus.—Hemicrania above the left eye, with a black spot before the eye which flutters; paralytic phenomena.

Spigelia.—Terrific pain which is on a level with, extends into the ball of the eye and is accompanied with amblyopia and temporary blindness.

Zincum.—Lancinating migraine with obscuration of vision; green, blue and yellow spots before the eyes; temporary blindness.

Tabacum.—This drug may be tried in those who do not smoke. The writer has, in his own person, observed five or six crises of ophthalmic migraine, with formation in the tongue and even a certain degree of aphasia; these have always coincided with an abuse of tobacco, and have not returned since he has nearly entirely given up smoking.

During the crisis *belladonna* would seem to be indicated; if the pain becomes very intense one may have recourse to antipyrine or caffeine.

Ophthalmoplegic migraine.—There is no known remedy. The following six drugs are indicated by their pathogeneses.

Spigelia.—Terrific supra-orbital pains which extend into the eye itself; ptosis of the upper eyelid; strabismus.

Belladonna and *stramonium*.—Besides the pain of migraine one finds in the pathogenesis of these two drugs paralysis of the upper eyelid and diplopia; these symptoms are more marked in *stramonium*.

Nitric acid.—Pressive headache, with radiating lancinating pains, most severe in the morning, with nausea and sensation of cold, difficulty in lifting the upper lid, diplopia. Hahnemann says, in his chronic diseases, that nitric acid has cured paralysis of the motor oculi nerve.

Phosphorus.—Headache above the right eye. Dr. Gallavardin has pointed out paralysis of the third nerve as a pathogenetic symptom of this remedy.

Curare.—Disturbances of vision, with ptosis of the upper eyelid; large doses cause paralysis of the third pair of nerves, dilatation of the pupil and external strabismus. Allen records a cure of right sided hemicrania with this remedy.—*L'Art Medical*, No. 12, 1891.

DR. MACFARLAN'S PROVINGS AND OBSERVATIONS WITH THE HIGH POTENCIES.—*Arum Triphyllum* 16m. Burning of pharynx and glottis; very nervous, raw feeling in chest, picking his nose all the time, light-headed, sleepy; smarting at end of penis; Feels sick, qualmish, giddy, slept unusually sound, eyes dim; pain under his left short rib. Helped a minister's sore throat of years' standing—in fact cured him. Woman could hardly stand on her feet they hurt her so, even the stockings when drawn on, gave her pain; feet feel so bruised; end of her tongue felt sore, round sore spots, as if scalded on the tongue; sores on throat and tongue, sensation as of an abscess forming high up inside the nasal bone on the right side, discharge of a large crust; little round hard pimples all over skin of body, legs, arms and face, about size of pinhead; feet hurt her so that it made her sick at stomach to walk; menses which were absent two months return; soreness and pain as if bruised in left mamme; nightmare. Just as she gets to dozing feels as if she would smother, starts up frightened; nervous at night, could not sleep; distressing hacking cough; mouth very dry; feels as if mucous surface would crack; wants to wet it, not to drink; has to get up in the night to moisten the mouth.

Asclepias tub. 45m.—Produced free perspirations and urinations without any other effects.

Asterias rub. 5c.—Pimples on side of nose and chin. Provers were women. Cured many cases where there was a disposition to pimples about the chin, mouth and face, generally occurring at the menstrual period and with young girls. Neuralgia opposite left molar teeth of lower jaw, sharp, piercing pain like a needle; lacks confirmation. One prover.

Atropine 6x.—Given in water every two hours cured long standing photophobia and watering of the eyes.

Atropine sulphate 30.—Wonderful effect in relieving pain attending ulceration of the cornea with violent conjunctivitis; sudden and marked cure of the photophobia. *Atropine sulphate* 6x given in water every hour produced on the third day great dimness of vision; cannot see glassware, such as tumblers and bottles; pupils not dilated, pain in and through eyeball, cannot see to read well. The accommodation is paralyzed. Cannot see to read even when holding the paper far

off. Type looks blurred; previously had acute normal vision; never wore glasses. These symptoms lasted over a week; mouth became so parched she could not speak without first moistening it. Patient took the medicine every hour for two weeks. Atropine sulph. 6 in water every two hours cured long-standing photophobia and lachrymation.

Aurum mur. 5m.—Legs appear slightly swollen and very tender along the inner side of the tibia, backache very severe.

Iodide of potassium cm.—After being given three weeks for its curative effects, produced choking sensation in the larynx, slight loss of voice, considerable increase of weight, improved appetite.

Iodine 17m.—The long internal administration of iodine high, produced in a girl symptoms of asthenopia; potted and rough skin; husky voice.

Ipecac 25m.—Violent spasmodic cough, aversion to food. Ipecac, and blanket wrung out of hot water to envelop the child, apparently cured a very severe case of membranous croup. Previously the child appeared hopeless.

Jasper 5c.—Leucorrhœa, aching in sacrum, no appetite, sensitiveness and sensation of weakness in bowels; dull frontal headache.

Kali bich. cm.—Redness in throat, irritation, swollen tonsils. A very reliable remedy in diphtheritic sore throat, loss of appetite, with hoarseness.

Kali carb. 24m.—Stiffness back of neck, shooting pains through his chest; shooting pains in muscles of extremities and chest.

Kali hyd. cm.—Larynx feels sore, gums and mouth sensitive; can hardly eat for soreness. Has cured many cases of rupia and syphiloderma. Fluttering sensation at the heart, giddiness; arose from bed thinking he would be smothered. After curing skin symptoms produced profuse watery discharges from the nose. Later on, discharge thicker, aching pains through both lungs, feels tired and weak, fluttering at heart and nervous. The high preparations have frequently cured syphilitic ulcerations especially on the legs, where the low did nothing. Sharp pains through the right lung, from the nipple backward, hoarse cough, pains through the breast, sighing respiration. Iodide of potassium, highly potentized and in various potencies, has relieved and cured the most persistent or chronic cases of megrim; often the cranial bones were sensitive, after the attacks passed off; more or less nausea and weak vision attending the cases. Follows well after belladonna.

Kaolin 45m.—Sore throat, soreness of both lungs, constipation. Has frequently cured cases of constipation, with large hard, dry, light red colored stools; great internal soreness of the chest often relieved; painful respiration—not walls of chest, but lungs apparently.

Kresote cm.—I know of no remedy which can compare with this in cases of cholera infantum, green stools, nausea, exhaustion, complete loss of appetite, dry skin, more or less fever, types one often sees in midsummer in large cities. Indigestion, loss of appetite. Caused sick stomach, disposition to vomit.

Lithia carb. 5c.—Cured a chronic syphilitic bluish ulcer, larger than a silver dollar, on the calf of the leg in a young man. Had to get up at night to pass water; frequent urination, with slight pain on straining; pain over the bladder; appeared to dilate the pupils. The latter lacks confirmation.—*The Homœopathic Physician*, February, 1892.

ODONTALGIA CURED BY IPECACUANHA.—Dr. Mossa, of Stuttgart, reports the case of a twenty-one-year-old and pale young man, of slender frame, who was much troubled with rheumatic pains. For eight days he had been afflicted with a very painful toothache; he had already had one tooth drawn yet the pain had not ceased, but taken on another form. It proceeded from a molar tooth of the superior maxillary; it was piercing in character and radiated into the right temple, ear and nose and even into the other teeth. The pain would appear paroxysmally every few minutes with a jerk as though the tooth were being pulled out. Worse by day than by night. The gums were, for some time, swollen and bleeding; this had been removed by nitric acid. His teeth were in bad condition in general; his tongue was coated and his appetite faulty. The symptom, *paroxysmal and jerking pain as though the tooth were pulled out*, led the writer to think of ipecacuanha, of which the patient received the first dilution, several drops, three times a day, in a teaspoonful of water. The toothache and neuralgia soon ceased.—*Archiv. für Homöopathie*, No. 2, 1891.

POISONING FROM THE EXTERNAL APPLICATION OF TOBACCO.—Dr. Auchè, of Bordeaux, France, relates the case of a man who, suffering from pediculi pubis, made a decoction of six and a half ounces of tobacco boiled in two quarts of water.

One morning he rubbed his entire body over with it, allowed it to dry and clothed himself; at half-past one in the afternoon this was repeated. Towards three o'clock he became suddenly sick at the stomach; giddy; his face darkened; he broke out into a cold sweat; his skin became extremely pale and his hands and feet trembled. The patient said that he experienced a sensation as if he were intoxicated; he saw as through a fog, yet he could make out the outlines of objects. The pupils were somewhat dilated, yet reacted to light. He heard well, yet he had a feeling as though he had cotton in his ears. From time to time he tried to vomit. The heart's action was very slow, the pulse small, filiform and scarcely perceptible. The symptoms continued for three hours and then gradually disappeared; the next day he had only a headache.—*Wiener Med. Presse*, No. 45, 1891.

INVOLUNTARY PROVING OF HYOSCYAMUS NIGER.—Dr. Frank H. Pritchard communicates the case of a woman, 42 years of age and in the best of health, who, suffering from sleeplessness, had been advised to take a few drops of hyoscyamus tincture. She poured out several drops—possibly twenty—into a small glass of water, stirred it up and took a swallow. She noticed no immediate effects and went to bed. She was soon driven out of bed with a dull griping pain and a desire for stool, having a darkish-brown diarrhoeic passage. That night she had several stools, the griping pain persisting in the original spot, the umbilical region. The next morning the diarrhoea continued uninfluenced; she had a violent frontal, left-sided headache. The next day after that the diarrhoea was gone but the headache continued; a terrific throbbing pain ran from the right upper jaw into the corresponding temple, the cheek swelled and a molar tooth, on the same side ulcerated, yet did not break. The swelling gradually decreased in size in the course of two days and all the symptoms wore off. The first two days there was excessive thirst and polyuria, especially worse at night. The menses appeared soon after and were more profuse than usual. This patient was extremely temperate in all things and never used tea or coffee.

ANACARDIUM IN BRAIN-FAG.—Dr. W. E. Leonard reports the case of a Miss B. a hard worked bookkeeper and stenographer, who came to him in 1887 complaining of being mentally tired out, and without another symptom. *Anacardium 2x* was prescribed hourly.

In commenting on the case, the author says that where this is the main indication, and brain-fag alone is back of such symptoms as weak memory, difficulty in collecting one's thoughts, slow in speech, becomes easily abstracted in conversation, and perhaps dull pain in the occipital region, this remedy will often give prompt relief. One frequently though not always finds the leading *anacardium* indication "entire relief of the headache by eating," and also aggravation of the same on any attempt at mental exertion. Such patients are extremely irritable, and occasionally ugly, according to the testimony of those around them.

But few remedies are indicated by the relief of head symptoms from eating, viz.: *anac.*, *lioh. carb.*, *lycopodium* (especially breakfast), *nux moschata*, and *nitrum* (after eating veal); while the aggravation by eating is quite common, especially under *nux*, *bryonia* (chiefly just after the heavy meal, dinner), *kali bich.*, and many others in less degree. But one remedy has a marked hunger during the headaches, i.e., *psorium*. According to Boenninghausen, the nearest remedies to *anacardium* in its mental symptoms are *lycopodium* in the highest degree, then *bell.*, *glon.*, *hyos.*, *stram.* and *sulph.*, all of which are known to congest the brain in a marked degree and produce corresponding symptoms.—*Minneapolis Homoeopathic Magazine*, January, 1892.

CENANTHE CROCATI IN EPILEPSY.—Dr. F. H. Fisk reports the case of Miss H. E. G., et. 16, sanguine temperament, well-grown, robust appearance, but dyspeptic. When eight years old would have absent-mindedness. Would be listless and inattentive for a few minutes, then would be all right. Health at that age good. These absent-minded spells would occur at irregular intervals, and recurred up to date of applying to me for treatment of epilepsy. Menstruation began at about the age of 12; epileptic convulsions were manifest about the age of fourteen, and grew more frequent and more intense in time. For the past six months the patient would have six to ten convulsions in twenty-four hours, if not kept stupefied with bromide of potassium. It required from sixty to one hundred grains per day to control the condition. The mind was beginning to show feebleness, and the functions of the body were subnormal. The convulsions did not occur at or near the menstrual period any more than at other times.

Enanthe crocata θ , 5 minims, in six ounces of water. One teaspoonful was given every three hours until there was some complaint of headache, then only every four or six hours. The result was that not another spasm occurred for three months when mental excitement brought on a convulsion. When the remedy would be withheld for a short time, slight mental fatigue would bring on a convulsion. The remedy was then continued for two years, during which time, and for one year since, there has been no recurrence of the attacks. The author states that he has treated five other cases with like results.—*Homœopathic News*, January, 1892.

ACONITE IN AN EPILEPTIFORM STATE.—Dr. E. T. Purdon reports the case of Mr. R., æt. 80 years, of excitable temperament. Lately his health has been good. November 3d, he was more excitable than usual, and sat up later, talking a great deal. Also had a little wine. Slept well and took breakfast in bed. November 4th, he felt drowsy and said he would not get up. At 11 A.M., he was found unconscious, with the limbs violently convulsed. He breathed very heavily with the characteristic expiration known as smokers' breathing. When seen two hours later, he was still in the same state, the convulsions of the legs being so severe that the skin was rubbed off of his legs, from the friction of one against the other; besides severe bruises in places. Aconite θ was now given in one-fifth drop doses, ice was applied to back of the head and cold-water cloth to the vertex. At this time, the pulse was 120 and irregular. The temperature was 104. The pupils were contracted. He lay in a comatose state save for the movements of the limbs. At 4 P.M. the temperature was 101, pulse 96. Consciousness was returning. At 10 P.M. of the same day, he was conscious but dazed. No actual paralysis, but cannot articulate properly. November 5th, quite conscious, pulse 76; temperature normal, skin moist; excitable and confused, but this he has been for a long time. November 6th, doing well.—*Monthly Homœopathic Review*, January, 1892.

KALI MUR. IN EPILEPSY.—Dr. C. C. F. Wachendorf reports the case of a man, æt. 45 years, who had an eruption in September, 1888, which disappeared until August, 1889. In November, 1889, the eruption was suppressed, and he began to have irregular attacks of "fainting fits." He would grow pale, a warm feeling following; then spasm, with pain in the cerebellum, and burning in the region of the stomach. Attacks nearly always preceded by fright or fear. *Nux*, *bufo.*, and *arsenicum* were each tried in turn, but failed. Then *kali mur.* 6x was prescribed on the indication, "*Epilepsy from suppressed eruptions.*" After the sixth day he had no attack. He still takes occasional doses of the medicine to keep up its action.—*California Homœopath*, January, 1892.

SABADILLA IN INTERMITTENT FEVER.—1. Pulse small, but somewhat jerking. Great ebullition of blood and throbbing of vessels. Sensation of stagnation of the blood.

2. Chill afternoons or evenings, returning exactly at the same hour, often without subsequent heat. Chill predominating especially on the extremities, with heat of the face. The shuddering chill constantly from below upwards. The chill is relieved by the warmth of the stove.

3. Heat most on the head and face, often interrupted by shuddering chill, constantly recurring at the same hour, thirst only between the chill and heat. Sweat often with the heat. Nights and mornings internal heat.

4. Sweat mornings in sleep. Hot sweat on the face with cold on all the rest of the body.—*California Homœopath*, January, 1892.

IPECAC IN INTERMITTENT FEVER.—1. Pulse greatly accelerated, but often imperceptible.

2. Chill generally of short duration, and soon passes into heat; internal chill as if under the skin, increased by warmth; chill with thirst; thirst, coldness of the hands and feet; chill mostly with thirst.

3. Universal continued heat with dry parchment-like skin after a short chill; evening, dry anxious heat; sudden attacks of general heat with cold hands and feet. The heat is mostly without thirst.

4. Very great sweat mostly at night; biting, mostly sour-smelling sweat, often also cold; in a room frequent attacks of hot sweat.—*California Homœopath*, January, 1892.

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APRIL, 1892.

THE TREATMENT OF ENLARGED PROSTATE.

BY W. E. BESSEY, M.D., C.M., TORONTO, CANADA

THERE are few more troublesome, distressing, or intractable diseases that one may be called upon to treat than enlargement of the prostatic gland; and few subjects more involved in pathological obscurity or more resistant to therapeutic measures than prostatic, renal and cystic calculi. Having had some satisfactory experience recently in the treatment of prostatic affections—congestion and chronic hypertrophy of the gland, and calcareous deposits, made up of minute concretions of calcium phosphate, which forms within the follicles of the gland, any or all of which give rise to a mechanical obstruction to micturition in men who have passed middle life which the profession generally have considered to be a permanent condition requiring operative interference, or mechanical means to overcome, I have felt constrained to bring the subject before you for your consideration. It is hardly necessary to enumerate the many operative proceedings that have been devised for the relief of this condition, but I may refer to a few to show the serious manner in which it is universally regarded.

A large number of patients with obstructive prostatic enlargement can be made comfortable by the use of a soft rubber, or a Nelaton or Mercier catheter, if it be carefully sterilized, in a 1 to 2000 corrosive sublimate solution, both before and after use, and W. Robertson, M.B. (*British Medical Journal*, May 17, 1884), origi-

nally suggested the use of injections of a corrosive sublimate solution (1 to 1000) in retention of urine from enlarged prostate, with catarrh of the bladder, introduced through a large prostatic silver catheter to the extent of three to four ounces warmed, and allowed to remain three or four minutes. This measure has been found to allay irritation and reduce the swelling in cases of acute congestion of the prostate. Free irrigation with hot water alone in acute cases will do the same, while in chronic hypertrophy and calcareous enlargement it has proved of no avail. To irrigate the prostatic inlets of the urethra or bladder successfully a suitable instrument for this purpose is necessary, without which good effects are not obtained and harm is done by the irritation of the interference. Of the devices the spirally grooved hard rubber catheter of Whitehead, Manchester, England, is I think the most satisfactory and cheapest. I have also used Linderschmidt's urethral and prostatic irrigator with much satisfaction. It should be borne in mind that the irrigation of the urethra with hot water, being regarded merely as a preliminary measure to treatment for the relaxing of spasmodic contractions of the urethral walls, and the cleaning away of foul secretions, it should be followed immediately after the mucous membrane has been thoroughly cleansed with an application of a weak solution of salt water one grain to an ounce; or a solution of corrosive sublimate 1 to 30,000, or tincture calendula 1 to 1000.

Harrison's device for tapping, or puncture of the bladder for retention of urine from enlarged prostate, through the perinæum and the enlarged gland by means of a trocar provided with a special canula has been followed by satisfactory results in chronic cases, but has not spread in popularity. Dr. Belfield's original operation, and McGill's admirable modifications of the work in the removal of portions of the prostate in those cases in which catheterism had become impossible, and in which cystitis had developed, and septicæmia or uræmic pressure seemed imminent, is an operation causing great shock to the nervous system, and the risk of hæmorrhage, and septic troubles is too great for it to be anything more than a *dermo-ressort* at best.

Groves' modification of Harrison's prostatectomy is an operation similar to an ordinary medium lithotomy opening of the membranous portion of the urethra close to the prostate, and the splitting up of the obstructing portion of the prostate with an ordinary lithotomy knife which is passed along a grooved staff. A large drainage tube is now inserted, through which a soft rubber catheter is passed

into the bladder allowing constant drainage ; or a canula with a stop-cock, may be used ; or the urine may be caught in a rubber urinal. As the healing process goes on in the prostate, cicatricial tissue is formed, which by its gradual contraction causes more or less atrophy of the obstructing portion of the gland, making the improvement progressive and permanent. This, although a formidable proceeding, is among the best surgical measures that have been devised, if we except the last but not least, supra-pubic puncture. This is easy of performance, and should be done with a trocar having a No. 10 canula with a stop-cock attachment to screw into the end after removal of the trocar to prevent leakage of urine. The canula should have a shoulder outside the stop-cock for the attachment of a piece of rubber tubing to facilitate the conducting of the urine into a receptacle.

The best surgical device that has yet been introduced for operations upon the enlarged prostate is the dome-trocar catheter of Dr. Fitch, Halifax, Nova Scotia, for tunnelling the intractably enlarged prostate, by which means the bladder is relieved at the time, and permanent release is secured for recurring retentions. This instrument is a long dome-trocar, the terminal third curved less than a common catheter or sound ; the dome with its fenestra resembles the end of a metal catheter, and is mounted upon a strong steel spring, which adapts itself to the outer canula and when this catheter end is pushed out, it occludes the point of the outer tube, which for additional security has a slight dorsal protuberance, so that it cannot catch or scratch the lining of the urethra ; it *is really a catheter* within a tubular trocar.

The mode of operating with it is as follows : the instrument with the dome protruding, is introduced into the urethra, till it comes against the obstruction and is arrested by the enlarged prostate, the left forefinger being in the rectum to define and steady the parts concerned, the pointed outer canula is advanced and passes easily through the gland into the bladder ; then the inside catheter is slid forward and enters the bladder with certainty, again occluding the point, and the urine is discharged as through an ordinary catheter ; a thumb-screw now fixes the protruded dome, and the instrument may be retained in the bladder twenty-four hours or until the perforation is sufficiently patulous, as shown by the instrument moving easily in it ; it may then be withdrawn, and a full sized metal catheter introduced twice a day or oftener, till the new channel is cicatrized and permanently established."

These are some of the many surgical devices which have been resorted to for the relief of this serious affection; to these must be added Sir Henry Thompson's plan, which consists in making a perineal incision into the membranous portion of the urethra just in front of the anus and passing the index finger into the bladder; then having withdrawn the grooved staff, insert in its place a large No. 20 vulcanized catheter, just penetrating the bladder and retained for several days; excellent results are claimed for this operation.

Notwithstanding the weight of the great names that have proposed these several methods they are only surgical, and therefore expedients, such as should be resorted to as the *dernier ressort*, when all remedial treatment has failed. I have something better, in my opinion, to suggest, which, in my experience, relieves the condition and renders surgical interference unnecessary.

An enlarged prostate is usually found to be about the most distressing affection a patient can be afflicted with, and one of the most troublesome and annoying, for, until very recently, the treatment of it has been little better than palliation, and the remedies proposed have come to be regarded as so unpromising, and unsatisfactory, that it came to be looked upon as incurable, and the mechanical obstruction to micturition, a permanent difficulty requiring surgical measures to overcome. Now, if we give a little brief consideration to the anatomical structure and the physiological functions of this gland, and the organ most affected,—the bladder—and the pathological changes which occur in this condition, it will furnish us with the data necessary to guide us in our efforts to arrive at a rational plan of treatment of enlarged prostate, with chronic cystitis, and thickening of the muscular walls of the bladder.

The anatomical structure of the prostate gland is given by Gray as a "pale, firm, glandular body which surrounds the neck of the bladder and commencement of the urethra." It is placed in the pelvic cavity behind and below the symphysis pubis posterior to the deep perineal fascia, and upon the rectum, through which it may be distinctly felt, especially when enlarged. In shape and size it resembles a chestnut. The prostate consists of two lateral, and a middle lobe. The two lateral lobes are of equal size separated behind by a deep notch. The third or middle lobe is a small transverse band, occasionally a rounded or triangular prominence placed between the two lateral lobes at the under and posterior part of the organ. It lies immediately beneath the neck of the bladder, behind the commencement of the urethra, and above and between the ejaculating

ducts. Its existence is not constant, but it is occasionally found at an early period of life, as well as in adults and in old age. In advanced life this or some other portion of the prostate often becomes considerably enlarged, and projects into the bladder, so as to impede the passage of the urine. It consists of glandular substance and muscular tissue. The muscular tissue according to Kolliker constitutes the proper stroma of the prostate, the connective tissue being very scanty and simply forming the trabecular between the muscular fibres in which the vessels and nerves of the gland ramify. The muscular tissue is arranged as follows: Immediately beneath the fibrous capsule is a dense layer which forms an investing sheath for the gland; around the urethra, as it lies in the prostate, is another dense layer of circular fibres, continuous behind with the internal layer of the muscular coat of the bladder, and in front blending with the fibres surrounding the membranous portion of the urethra. Between these two layers strong bands of muscular tissue which decussate freely form meshes in which the glandular structure of the organ is imbedded. In the part of the gland which is situated anterior to the urethra, the muscular tissue is specially dense, and in this situation there is little or no gland tissue, while in that portion which is behind the urethra the muscular tissue presents a wide-meshed structure which is densest at the upper part of the gland, that is, near the bladder; it becomes loose and sponge-like toward the apex of the organ, directed forward to the deep perineal fascia. The glandular substance is composed of membranous follicular pouches opening into elongated canals. The follicles are connected together by areolar tissue supported by prolongations from the fibrous capsular and muscular stroma, and are enclosed in a delicate capillary plexus.

Vischer says: "The prostate is a symmetrical body composed of a medium and two lateral lobes; the existence of the former, however, is said by some never to be present in a urinal gland (Thompson, Morgagni, Lantorini, etc.). Its structure consists of a dense stroma of unstriated muscular tissue, in the meshes of which are found tubular glands lined with cylindrical epithelium."

Ellis says: "The prostate is essentially a muscular body, consisting of circular or orbicular involuntary fibres—its circular fibres are directly continuous behind, without any separation with the circular fibres of the bladder."

Dewitt says: "The prostate is essentially a circular involuntary sphincter to the neck of the bladder, and expeller of the seminal

fluid; but although it contains many mucous glands and follicles intermixed with muscular fibres, it is by no means entitled to the name of gland."

"Besides it contains a small vesicle at the mouth of which the ejaculating ducts open, which is believed to be the male homologue of the female uterus." The involuntary muscular tissue which enters into the composition of the prostate itself, and the vessels of the gland also have in their coats unstriated or involuntary muscular fibres—and these exist in the coats of the bladder in a very marked degree. Now these involuntary muscle fibres are more or less extensible and when normally stretched have an organic tendency to contract. This is seen in the uterus, bladder, and diastole of the bloodvessels. But when abnormally distended they gradually lose their power to contract or become paralyzed and remain permanently dilated or elongated as seen in varicose veins—dilatation of the right side of heart, etc. Enlarged prostate consists essentially in a hypertrophy or enlargement of the natural muscular structure and incidentally by congestion of the glandular.

De Witt says of it: "The affection is peculiar to advanced life. The increase may be but slightly above the ordinary chestnut size of the gland, or it may render it as large as a man's fist or larger. It may affect the whole organ, especially the lateral lobes, pretty uniformly in which case the posterior portion of the gland is greatly lengthened, or it may affect one side more than the other in which case the canal will be twisted, or it may affect the postern median portion which lies between the ejaculating ducts enlarging it into what is commonly called the middle or third lobe."

Sir Henry Thompson says: "A middle or third lobe does not exist in health; it is *pathological anatomy* and purely the result of unnatural enlargement. In youth the prostate becomes enlarged from interstitial plastic effusion—the result of inflammatory action. In age there is an unnatural development of the prostatic tissue itself."

Dewitt further asserts, "The consequence of this enlargement of the middle lobe is that there is a projection at the very orifice of the urethra, causing a most serious impediment to the issue of the urine. Hypertrophy and derangement of the muscular fibres and near the trigone may produce a transverse bar at the neck of the bladder. The enlargement may be due to an increase of the organ generally; or to the development of one or many masses of fibrous tissue exactly similar in structure to those concentric masses of muscular fibre

which are developed in the womb, and are commonly known as fibrous tumors of the uterus.

"One or more of these masses, involving more or less glandular tissue may be developed alone, and may project as a pedunculated tumor, or it may be contained within the mass capable of enucleation, and may constitute the whole disease, or it may be combined with general hypertrophy."

The causes of this hypertrophy appear to be clearly associated with local irritation, congestion and disturbances of the circulation of these parts as from masturbation, excessive intercourse, irritating injections or urethritis. It may be the result of an old gonorrhœa or gleet; according to Erand and Montagni one-half are gonorrhœal; the weakness or local paralysis following a long continued or sharp attack of gonorrhœa forming a condition of chronic congestion of the prostate gland and mucous membrane lining of the ducts and passages of the neighborhood. But any absolute positive knowledge of the cause of this hypertrophy is as absent as that respecting tumors, or enlargement of such other glandular structures, as for example, the tonsils or thyroid, cases of which are as common in early life as this is in after life. It commences, says Sir B. Brodie, about the time the hair begins to turn gray, and when the arterial coats begin to become atheromatous, but this change is not universal, although frequent. Persons not having a history of disease of the sexual organs, masturbation, or sexual excess, are seldom affected with this distressing complaint, and atrophy often takes its place.

Sir Henry Thompson regards this change in the prostate of old men as abnormal and exceptional, and gives the following statistics: Out of forty-three specimens from men of over fifty, two men atrophied or wasted, nine slightly enlarged, five seriously enlarged so as to give rise to troublesome symptoms.

As to age, Sir B. Brodie thinks it begins at forty-five. Sir H. Thompson believes the change rarely begins before fifty-five or after seventy.

Symptomatology.—The symptoms are two-fold, viz., those of which the patient complains and those detected by physical examination. Many writers have given special prominence to special points in diagnosis and treatment, but the following summary covers the whole subject. By introducing the finger, well oiled, into the rectum, and passing the bulb over the front wall, the sense of touch will reveal the actual conditions present, viz., whether there is a tumor of the right, left, or central lobes, or whether there is atrophy.

In using a catheter, if there be enlargement of the middle lobe, there will be an obstruction at the neck of the bladder, or, after voiding all the urine possible without a catheter, its use will show a residual urine of some ounces.

According to the researches of Dr. Messers, conducted at Greenwich Hospital (see *Medico-Chirurgical Transactions*, vol. xliii., p. 152), it would seem that such obstruction exists in 20 per cent. of all prostates over sixty years of age. Such patients believe themselves to be sufferers from *internal piles*, because of the sense of weight in the perinæum, the tenesmus, slowness, and difficulty in making water. The bladder soon becomes irritable, with frequent calls to urinate, and as it cannot be completely emptied on account of the projection into the urethra formed by the tumor, the retained urine becomes ammoniacal. A fit of complete retention may be brought on by exposure to cold or excessive venery, in fact, by anything capable of producing acute congestion of the part. As ordinarily no treatment is attempted to arrest the progress of such cases, they being looked upon as incurable, the enlargement goes on, the obstacle continues to increase, the bladder is constantly distended with ammoniacal urine; chronic cystitis increases, the ureters become dilated, the kidneys affected, a state of chronic catarrhal inflammation of the urinary apparatus is established, and finally pyæmia or complete retention ends in uræmic poisoning and death.

Now these are the anatomical, physiological, and pathological data which lead to the conclusion that chronic hypertrophy of the prostate gland, need not be allowed to continue to exist in any case, and the consequent retention and difficulty of voiding urine; the chronic cystitis, misery, and death, can and should be prevented, and when that is not done the life is lost, or the consequent misery and sufferings is fairly chargeable to the blind negligence and voluntary ignorance of the members of the profession having the case in charge.

It is upon the foregoing considerations, of the greatest import to the surgeon, viz., anatomical and physiological facts, that the plan of treatment I have been pursuing for the past three years in such cases, with the greatest comfort to myself and satisfaction to my patients, has been based. And in this connection I desire to state that the merit of originating the plan of non-surgical treatment of enlarged prostate gland is due, and is cheerfully accorded, to the late Washington J. Atlee, M.D., of Philadelphia, who in 1878 first announced the successful results of his experience with this method—

although his plan was only experimental, and lacked the completeness and success which now attends this method of treatment.

Atlee's treatment was based upon the consideration that the prostate is largely made up of involuntary muscle-fibres, and enlargement of the part was chiefly due to a condition of enlargement or congestion, acute or chronic, of the capillary blood-vessels, and that we have in ergot an agent capable of acting upon unstriped muscle-fibres and causing it to contract, and that "in all cases of relaxed or stretched involuntary muscle-fibres this medicine will meet the requirements as shown by its action upon the enlarged uterus, the distended bladder, in hæmorrhage, in congestion of the capillaries, etc." And he argued from this that, "it is calculated not only to contract the muscular fibres of the prostate, but also primarily, the capillary vessels, and secondly, as a consequence of muscular contraction, its follicles and mucous glands, and thus the size, as well as the nutrition, of the gland would be diminished."

As ergot is well known to be spasmodic in its action, and therefore only temporary in its effects; and, as cohosh or cimicifuga possesses the power of producing tonic or permanent contraction of involuntary muscle fibre, it suggested itself to my mind as the drug necessary to complete the good effects of the ergot in such cases, and I have been more than pleased with the results. My experience with these two agents has gone to show that they will accomplish the desired result, not only in mere hypertrophy of the gland, but also in enlargement from myomatous growth, as in fibroid tumors of the uterus. By the combination of the cohosh the weakness of the sphincter and muscular walls of the bladder is greatly lessened, and the power of the bladder to expel its contents greatly augmented at the same time that the mechanical obstruction to catheterism is removed by the lessening of the size of the organs. My experience, with the use of ergot alone, was not completely satisfactory, as the symptoms after a time returned; but, since using the combination of the two drugs, ergot and cohosh, I have had no complaints, and the number of old men who have been able to drop the use of the catheter, after having been constantly dependent upon its frequent use for years, has been surprising, while the expressions of their gratitude is music to our ears.

The late Dr. Atlee reduced his views to three propositions, which I have extended to six; they are as follows:

1. The prostate and its vessels are supplied with unstriped (involuntary) muscle-fibres.

2. The bladder is an organ having both voluntary and involuntary muscle-fibres in its coat.

3. The therapeutic action of ergot is known to be to contract unstriated, or involuntary muscle-fibres, and therefore, on the muscular walls of the bloodvessels, as seen in its action upon the uterus, and in diminishing the calibre of the bloodvessels.

4. That while the action of ergot upon unstriated muscle-fibre is pronounced, its spasmodic character allows reaction to take place, and it is therefore followed by a degree of relaxation or exhaustion which limits its usefulness.

5. That cohosh (*cimicifuga rac.*) is known to produce tonic or persistent contractions of involuntary muscle-fibre through its action upon the sympathetic nervous system, on which it produces a soothing effect (which in over-doses amounts to depression); that it relieves muscle-pains and allays nervous irritability, as shown in its action in relieving irritability and excitability of the heart, with angina pectoris—muscular rheumatism, chorea—and its admirable action upon the uterus in the relaxed conditions following severe labor; in menorrhagia by imparting tone to the muscular walls of this organ; in its action upon the bladder in chronic cystitis, soothing pain and allaying irritability; while its administration is followed by a true tonic effect upon the involuntary muscles, which seems to be permanent and lasting.

6. That the use of *cimicifuga racemosa* (or its active principle, *cimicifugin*), in conditions of relaxation or debility of the involuntary muscular system; in chronic congestion with pain, swelling, and hypertrophy of the prostate gland in debility, with irritability of the walls of the bladder, uterus, heart, urethra, etc., cannot be too strongly recommended, especially in combination with ergot (1 part c. to 2 parts e.), whereby a sharp, decided, energetic, and continuous action is secured, with lasting benefit to the patient. Many remedies have been tried for the purpose of producing absorption of the tumor caused by enlarged prostate, such as potass. iodide, potass. bromide, potass. sulph., potass. mur., etc., but no satisfactory results have followed the use of any remedy but ergot or cohosh.

In complete retention of urine from enlargement of the prostate from acute congestion or inflammatory action, a hot bath, fomentations, or leeches, etc., with aconite or ferrum phos., to arrest the inflammation, should be promptly resorted to. The first cardinal indication is to relieve the patient's distress from the distended bladder, and this can be almost always done by using a soft rubber catheter

of small size (No. 4), and injecting hot olive oil into the urethra before trying, either through the catheter to be inserted, or a larger one carried up to the point of obstruction. The surgical principle is, that the catheter should be passed per urethra, if possible; failing this, the next resource is puncture of the bladder; and this should always be by the rectum with a curved trocar, unless prevented by rectal disease, in which case the puncture is to be made above the pubes. Having succeeded in relieving the bladder, the next step in the treatment of enlarged prostate is to irrigate the prostatic portion of the urethra thoroughly with very hot water, to which sublimate (per chloride of mercury) 1 part to 10,000 has been added. I then order the patient to have injected into the rectum 10 drops of fld. ext. ergot, with 5 of tinct. cimicifuga rac., every two hours, or 30 to 15 every six hours, as circumstances may indicate. This is persisted with, and the hot-water irrigations are repeated every twelve hours until the catheter can be readily introduced.

After that I began the use of steel sounds (*a la* Pratt) heated in hot water and well oiled, introducing only such sizes, gradually increased, as can be introduced without force. The medicine is continued, at first, every two hours, until the swelling has ceased to prevent the use of the catheter; then, the frequency of the medicine is diminished and the doses increased. For the first few days I introduce the catheter every twelve hours, while necessary, to relieve the bladder, usually until the third day, sometimes much less, or until the obstruction to urination from the swelling of the prostate has been removed, and, if the remedies be continued, the patient soon recovers entire control of the bladder, and the use of a catheter ceases to be a necessity. The cohosh will be found to have a surprising effect in toning up the relaxed genital organs. The remedy, however, must be persisted in, at longer intervals with larger doses for a sufficient length of time to enable the patient to recover entire and complete control over the bladder, after which a dose should be taken at bed-time for several weeks, or months if necessary, to restore the weakened bladder to a condition of usefulness. By this means, prostate glands that have been chronically inflamed and enlarged for years, may be effectually relieved, and comfortable health secured into advanced life.

I have just heard from an ex-M. P., in the Canadian Northwest, City of Winnipeg, who had been a sufferer from enlarged prostate, with chronic cystitis or catarrh of the bladder, for nine years, or since he had been treated for a severe attack of gonorrhœa. I now be-

came the twentieth practitioner into whose hands he had placed his case, hitherto to no purpose. He was tired of spending money, had lost confidence in the profession, and was fast becoming tired of life also. He was obliged to make water very frequently, getting up ten or twelve times a night. I succeeded in washing out the bladder with Linderschmidt's Irrigator, and solution corrosv. sub., 1 to 4000, after which I began passing steel sounds gradually, one of a larger size each day, and gave him a dose of ergot and cohosh every two hours. I dropped to every four hours, doubling the quantity of the remedy, and in three days found him much relieved, and in three weeks he had ceased to be obliged to get up to make water during the night, and in three months—declaring himself cured—he left Toronto for his home in the far West. Since his return, he has sent me many cases in middle-aged men suffering from enlargement of the prostate, and other bladder troubles.

I have placed all like cases on the same treatment, with the same beneficial results in every case—some sooner, some later, but all being much relieved in a few days. In one old gentleman, who (for want of faith) persisted in carrying and using his catheter, as he admitted, long after there was any real necessity remaining for its use; persistent use of the remedy has not only cured the bladder difficulty, but it has much improved the general tone of the system and appearance, enabling the old gentleman to do the town every day and talk politics as a pastime.

In this connection, I wish to quote Dr. Atlee as saying, that he mentions "a case in particular," because a post-mortem examination proved that the prostate gland had been diminished in size by the treatment. The patient was eighty-two, and had suffered from retention from enlarged prostate; but his last few months had been made more comfortable "by taking a dose of ergot every night." His urinary organs were kept in good condition, he was able to do without a catheter, and he enjoyed much better health in consequence until he finally died of old age." Surely, any plan of treatment, or remedy, that will relieve the distresses of these suffering old gentlemen is better than surgical torture, mangling, or murder.

ICHTHYOL is most efficacious in acute inflammations, whether blennorrhagic or not. In metritis of the cervix it is most valuable and in cervical erosions the application of the pure drug will cause prompt healing.—Dr. Richard Bloch, *Archives of Gynecology*.

OXYGEN AND ITS THERAPEUTIC INDICATIONS.

BY H. EVERETT RUSSELL, M.D., NEW YORK CITY.

"CAN consumption be cured?" This is a question frequently asked, but not always satisfactorily answered. It certainly can be cured in most instances if taken in time, and the remedy which will surely arrest the ravages of this dread disease in perhaps nine cases out of every ten, is the compound of oxygen and nitrogen administered by inhalation.

Unquestionably cod-liver oil, the hypophosphites of lime and soda, cream, the indicated homœopathic remedy and other dietetic and medicinal treatment, have a beneficial effect upon consumption, but in all probability, oxygen will benefit any case more than all the above measures put together. It is well-known that no consumptive can take a deep breath, even with the greatest effort (and in too many cases the patient does not make this effort.) One of the first things which oxygen will do for the phthisical patient is to compel him to breathe deeply, the gas being compressed and thus forced into the lungs without any effort on his part. This fact alone makes the inhalation of oxygen of great benefit. It is also valuable on account of its antiseptic properties. In an advanced stage of consumption, the lungs are full of impurities which are directly acted upon by oxygen. They are not only rendered inert to a considerable degree, but the patient finds, to his surprise, that it is easier to expel these deleterious substances by the act of coughing. Hectic fever is removed by the frequent inhalation of oxygen. This adds immensely to the comfort of the patient, for it is doubtful if there is any symptom of consumption which annoys the sufferer more than the afternoon rise of temperature, together with the depression which necessarily follows. The night-sweats, "all-gone" feeling, the great mental depression which we often see, notwithstanding the oft-repeated assertion that consumptives are always hopeful, are speedily relieved. In short, oxygen is the remedy *par excellence* for consumption.

This agent will also be found of great benefit in neurasthenia, insomnia, dyspepsia, and other nervous diseases, as well as in all affections of the heart and lungs. In cases of nervous exhaustion the temperature is usually one or two degrees lower than it should be. This is an annoying and often a persistent symptom. Now, if a

patient suffering from this disease presents himself with a temperature of say ninety-six and a half to ninety-seven degrees, all we have to do is to administer three inhalations of oxygen, and the temperature rises to ninety-eight and a half, and he will usually admit that he feels much better. He may enter the office looking pale and languid, and the chances are that he will leave it at the expiration of fifteen minutes, with a natural color on his face, and appearing quite recuperated. If this treatment is continued for a few weeks or months, the patient will in most instances be entirely cured, sometimes without any medicine whatever. It may be added that oxygen is, in the writer's opinion, the best agent for the removal of the great exhaustion and depression following an attack of la grippe. As this exhaustion is the only dangerous part of this latter disease, anything which tends to relieve it will often save the patient's life.

In administering oxygen, the patient should be directed to expel as much breath as possible from his lungs, then holding the nose, should inhale the gas slowly until he feels he has taken as much as he can comfortably. Let him hold this while he counts "five," and then slowly expel it through the nose. After waiting at least two minutes, repeat the operation until three breaths have been administered. This may be done once, twice, or three times daily in chronic cases. In acute diseases, such as heart-failure, angina pectoris, the advanced stage of pneumonia, etc., it may be given every hour, or even every half-hour, according to circumstances. In advanced cases of phthisis and pneumonia, also in heart-failure, croup, and diphtheria, the nose cannot be held as it causes pain. Under these circumstances the oxygen should be inhaled as deeply as possible for about thirty seconds without holding the nose. This operation should be repeated with intervals of one minute until the patient is relieved.

Oxygen is indicated in a great variety of disorders, as before stated, but there are two diseases in which it should always be employed, when practicable; these are nervous exhaustion and consumption.

CURETTING IN UTERINE CANCERS AND FIBROIDS.—Where hæmorrhage is the dominant symptom in fibroids curetting is useful, but must be rejected if the fibroids are large and the symptoms of compression predominant. Fibroids may even diminish in volume in consequence of curetting. In cancer which has not yet invaded the recto-vaginal, or the vesico-vaginal wall, curetting, followed by cauterization, has seemed the best treatment for the temporary relief of hæmorrhage, pain and offensive discharge.—*Archives of Gynecology.*

THE TREATMENT OF SYPHILIS.

BY EDWARD M. GRAMM, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

To the majority of physicians the treatment of syphilis means the administration of mercury in the early stages and the iodide of potash in the late stages of the affection. While it is true that mercury is of sovereign value in a great many cases, and must usually be applied at some time in almost all cases, yet there are in this malady as clearly defined indications for the selection of remedies as in all other forms of disease. It is for the purpose of calling attention to some of the remedies that I have had called for in cases that came under my care that this paper is written. All who will approach a case of syphilis with a mind unbiased as to the remedy to be administered because the disease bears the name of syphilis, will be surprised to find the well-defined groups of symptoms that they will elicit in a certain percentage of their cases that will lead them away from mercury and as certainly lead to the application of other remedies, and that, too, with relief of the symptoms for which the given medicine is indicated.

The question as to whether a case in which other remedies than mercury are called for will be cured by the medicines given must, I think, be answered in the affirmative. Syphilis is no different in regard to the processes that determine destructive changes or the processes of repair, by which, on the one hand, disease changes are caused, or, on the other hand, the impulse to recovery is given to the organism. The pathological changes discoverable by us are different, but the same laws are operative in an organism infected with syphilis as in one where another malady is the cause of ill health. For the same reason the manifestations of disease in a patient who has acquired syphilis should be given an equal regard as to selecting the remedy applicable to a given case, no matter to which remedy the symptoms may lead us. If the law of homœopathy is a true guide for determining what we shall prescribe in other diseases, it certainly is applicable in this affection; and if remedies will cure in a diseased organism other maladies whose symptoms correspond to those produced by these medicines in a person in good health, how can syphilis logically be excluded from the list?

The time at which remedial measures are to be instituted is a

matter of discussion where the medicines are to be given in such doses as will mask the affection by their size, and where a drug affection is likely to be produced that will obscure the symptoms so that the progress of the disease cannot be properly followed. Where potentized remedies are given it seems to me that the time to give them is when they are indicated by symptoms characteristic of them, whether that be before or subsequent to the appearance of the first skin manifestations. To wait until the disease has had almost two months in which to disturb the economy after the chancre has announced the fact that infection has occurred, if symptoms announce ill health, seems reprehensible to me from a medical standpoint. If the administration of remedies be postponed for politic reasons, for instance to make the patient himself thoroughly convinced that he has acquired the disease, such reasons should not be laid down as of general utility, but should be limited to exceptional cases.

Of the local measures to be employed for the chancre I will say nothing here, passing on to a consideration of the remedies that are called for by systemic symptoms.

Others things being equal, the form of mercury in my estimation that covers most cases early in the affection is the yellow iodide. A perusal of its pathogenesis will convince any one that a perfect picture of syphilis is presented by it. It is distinguished from the red iodide, that so many of our physicians are in the habit of using early in the disease, by the following symptoms:

<i>Mercurius iodatus flavus.</i>	<i>Mercurius iodatus ruber.</i>
Moodiness, depression of spirits; soon changes to lively mood.	Low-spirited, depressed.
Dull, frontal headache, with pain at root of nose.	Sensation as if bound with a tight cord in frontal region.
Headache on top of head, or on right side.	Vertex very hot, with slight pulsation at 11 P.M.
Dull headache on awakening in morning.	Headache, worse in afternoon and evening; dull, stolid.
Stiffness and soreness in occiput, also when touched, more to the left and down back; worse when lying.	Pains in the bones of the head, chiefly occipital.
Many eye symptoms.	Fewer eye symptoms.
Tongue coated bright yellow at back, tip and edges red.	Tongue dry, wants to wet mouth; scalded feeling, small blister on point.
Less salivation.	Profuse flow of saliva and aching pains in teeth of lower jaw.
Throat symptoms less severe.	More marked and more severe throat symptoms.
Burning in throat.	Sticking in throat.

Mercurius iodatus flavus.

Throat dry, with frequent empty swallowing; burning when swallowing saliva.

Throat symptoms more apt to be worse on the right side.

Pain in throat more apt to be worse from swallowing hot things.

Desire for acids.

Soreness, with heaviness of all limbs, with dull frontal headache and soreness of bones of face; soreness, with lameness of hands and fingers; heaviness of whole body, with soreness as if one had been beaten.

Worse during rest.

Headache better when mind and body are actively engaged.

Sleepless, without restlessness, before 1 A.M.

Feels worse in a warm room.

Less tendency to sweating during night.

More irritability of skin, as shown by itching.

Eruptions more superficial, small or large papules.

Mercurius iodatus ruber.

On waking throat sore, feels scalded; worse during empty swallowing.

Throat symptoms more apt to be worse on the left side.

Desire for salt.

Worse during motion.

Restless after midnight.

More tendency to sweating during night.

Eruptions deeper seated, papular, pustular or ulcerative.

The symptoms of the yellow iodide seem to be of a more superficial character than those of the red iodide and seem more regularly connected, just as the early symptoms of syphilis show themselves; while those of the red iodide are more irregular, similar to what is found in the later stages of syphilis, and affect deeper structures.

To take up the various stages and conditions as they are found in a case in which systemic symptoms are beginning to show themselves, the inguinal adenopathy, or rather the enlargement of the lymphatic chain nearest the point of infection will engage our attention. Here the mercurial preparations will not always be indicated by the symptoms of the patient. The iodide of arsenic has proven itself of curative value where lymphatic enlargement was the most prominent manifestation, particularly where the patient complained of being very weak.

Arsenicum and baptisia have ameliorated the fever which is found in a certain percentage of the cases just before the outbreak of the first eruption.

I do not lay any great stress on the naked eye appearances presented by the various eruptions, as to whether they are macular,

papular, pustular, etc., although there is no doubt in my mind that kali bichromicum is of much greater value in early pustular eruptions than any form of mercury. The mixture of different forms among each other in early syphilis is of value as indicating the virulence of the disease, and calls for the administration of mercurius corrosivus. In one case of papulo-squamous eruption that came under my notice carbo animalis was the only remedy that could possibly cover the symptoms the patient, a girl of 19 years, presented. The result showed the wisdom of the selection of the remedy, for all traces of the eruption disappeared very rapidly, more rapidly, in fact, than this form of eruption usually disappears. Stillingia is another medicine that should be thought of in a squamous eruption where there is a tendency to the appearance of pain apparently located in one of the viscera of trunk, stomach and liver mainly. At the present time I have a case under observation in which arsenicum is markedly improving a case of palmar and plantar squamous eruption that occupies almost the whole of those regions.

The marked rheumatoid pains that are complained of early in the disease are best combated by appreciable doses of the iodide of potash, five grains after meals being the usual dose that promptly cured these pains in a great many cases that I have treated. It should, however, be borne in mind that the employment of the iodide of potash must not be persisted in for any length of time, but the remedy must be replaced by some other so soon as the pains are conquered.

For the headache mercurius iodatus flavus is applicable where it is frontal in character, pain dull and rather worse in the morning, the patient often receiving nux vomica as an intercurrent where the yellow iodide is called for. The headache of mercurius iodatus ruber is of a more tensive character, and is inclined to be worse in the latter part of the day. Belladonna, with its well-known train of symptoms, has relieved some cases.

Where there are no active symptoms calling for remedies directed to urgent systemic conditions, plumbum has been efficacious in combating the alopecia of early syphilis. I am, however, in the habit of using one of the lotions recommended for the purpose of stimulating the hair follicles.

Iritis, appearing early in the secondary stage, is met by most physicians by the administration of the red iodide. I am satisfied that far better results will be obtained if the yellow iodide is sub-

stituted for the former. A number of cases that have received the yellow iodide for this affection have improved in a much more rapid and marked manner in my hands than those in which the red iodide was used. The red iodide is more useful, it seems to me, where iritis sets in late in the secondary or in the early tertiary stage, if the affection is not due to the breaking down of minute gummata. Where gummatous degeneration is the cause of the inflammation, kali iodatum is called for, often in large doses.

The characteristic offensive leucorrhœa that so many syphilized women suffer from can readily be relieved by vaginal douches of the bichloride of mercury in the strength of one part in 4000 of water, one douching per day often being sufficient to control this annoying feature of the disease, as well as serving to prevent the formation of mucous tubercles around the vulva and adjacent regions.

In the sore throat of the secondary stage of the disease, mercury is often very efficacious, the red iodide affecting more prominently the right side and the yellow iodide the left side. Belladonna, phytolacca, lachesis and other remedies often being called for and proving curative.

The late tuberculo-ulcerative eruptions require kali iodatum, mercurius iodatus ruber and other remedies. One case that I treated showed in a marked manner the value of close individualization in the manner in which a tuberculo-ulcerative patch of eruption located upon the face disappeared under the administration of lachesis, the remedy being called for by the characteristic gastralgia of lachesis as well as by other symptoms of the remedy. That the prescription was the proper one for the case in question was also evidenced by the restoration to a general feeling of good health that set in so soon after its administration that there could not be any possibility of questioning the relation of cause and effect.

Where localized gummatous deposits within the skin break down late in syphilis, it may be necessary to combine the red iodide of mercury with the iodide of potash, either mixing the two substances in the one solution (in which case a single chemical compound, the double iodide of mercury and potash, is formed), or giving the two remedies in alternation; in the latter event it is necessary to give the iodide of potash immediately after meals, and the red iodide of mercury between meals, or the iodide of potash alone may be sufficient to cure this disagreeable condition. However, much more rapid results will be obtained if the deep ulcers that are formed by

this breaking down of the cutaneous gummata are swabbed out occasionally with crude carbolic acid.

Where diffuse gummatous deposits are in danger of breaking down, particularly if they are located where such ulceration will endanger vital neighborhoods as, for instance, in the throat, it is necessary to use the iodide of potash in heroic doses; as many grammes per day as the patient's stomach will tolerate. Where such danger exists there is no time to allow the normal vital changes to bring about repair in the usual way, but it becomes imperative to administer the iodide of potash in such doses as will insure that it will act in its physiological manner to cause rapid absorption of the gummatous material. Temporizing means loss of valuable time and tissue that can never be replaced. The homœopathic law finds no application under such circumstances, for the remedies selected according to it have not the time to give nature that impulse toward recovery that they can do under other circumstances.

At times it is necessary to bring the system rapidly under mercurial influence, in which case the method of inunction by Sturgis, of New York, will prove the best in the majority of instances. It consists in allowing the patient to wear within his stockings upon the soles of his feet a piece of muslin cut to fit the soles accurately. Upon this mercurial ointment is thinly spread. This muslin is to be taken off at night, the feet washed and the ointment applied in a similar manner on the next day.

In conclusion, I would say again that it has not been the writer's intention to prepare an exhaustive paper upon the methods to be employed to meet all the indications to be seen in a single case of syphilis, but rather by indicating some of the main features of such a course of treatment, to elicit a discussion that may be the means of bringing together the experience of those members of our Society who have had the good fortune to treat cases of this widespread plague.

VERIFIED SYMPTOMS OF CALCAREA PHOSPHORICA.—Vertigo with constipation of old people.

Headache of pale girls or those that have much mental work, with rheumatic pains in arms and legs.

Empty, sinking sensation in stomach extending into the bowels; eating relieves this distress.

Diarrhoea in emaciated children; diarrhoea with headache. In chlorosis of young girls near puberty, it is one of the best remedies.—Dr. C. M. Foss, in the *Transactions of the Maine Homœopathic Society*, vol. v.

A CASE OF CATALEPSY CURED BY NAJA.

BY F. E. WILLIAMS, M.D., HADDONFIELD, N. J.

(Read before the West Jersey Homœopathic Medical Society.)

CATALEPSY is one of the hysteroid affections. The seat of the disease being in the brain and spinal cord. Its symptoms representing a morbid change in the nervous system. In the majority of cases it is complicated with hysteria, and its paroxysms last from a few minutes to several days.

In this condition the will seems to be cut off from certain sets of muscles, or from all of the muscles, and whatever position an affected part may be placed in, so it will remain for an indefinite period.

Cataleptic attacks may, or may not be accompanied with unconsciousness. Sensation is usually impaired, or entirely lost.

The disease may be caused by emotional disturbances, injuries to the head and spine, or it may be hereditary.

In December, 1890, I attended a patient through a severe attack of "La Grippe," followed by bronchitis. Two weeks after recovery from this attack, the patient from imprudent exposure, contracted pneumonia, from which she made a good recovery in about two weeks.

The patient was a lady of nervo-sanguineous temperament, delicate all her life, of thirty-nine years, and the mother of six children.

On the twenty-ninth of March, two months after the attack of pneumonia, I was hurriedly summoned to see her, and was informed by the husband that the patient had been taken a week previous with attacks of suffocation, coming on suddenly, lasting a second or two, and passing off as suddenly as they appeared. She had been having five and six of these attacks in the twenty-four hours, occurring frequently at night while lying quietly in bed. Between these spells she had attended to her domestic affairs as usual, and the family were not much alarmed until the day previous to my visit, when she had twelve attacks of an entirely different nature from the former ones, lasting much longer, more severe in every respect, followed by great prostration and irritability, sleepy and stupid, with a desire to be alone. In three days another paroxysm occurred, and on an average of every two to three days thereafter with varying severity. I was particularly anxious to witness one of these paroxysms, and arranged my visits at different hours, hoping to be fav-

ored, but with the usual perversity of her sex, she seemed to prefer any time previous, or just after my trips.

We were feeling somewhat encouraged by the middle of April, the paroxysms growing less severe, and at longer intervals, when the disease took a sudden turn, and the attacks followed each other more closely than ever before, leaving her so prostrated, that by the last of this month she was confined to her bed, and unable to raise herself without assistance; so great was the prostration that the prognosis became unfavorable. A few days later, I succeeded in finding the patient in one of the paroxysms, having previously been obliged to depend entirely upon the observation of the attendant, and the memory of the patient which was much impaired, for guiding symptoms. Oddly enough for some time after this first exhibition, she did not hesitate to have an attack during nearly every visit I made.

The average paroxysm consisted of the following symptoms: Suddenly, without warning, respiration ceased; as she expressed it, "everything seemed to stop;" she would clutch her hands or grasp any near object; head thrown slightly back, muscles of neck rigid, eyes wide open and pupils dilated; mouth half open and rigid; muscles of back rigid, occasionally opisthotonos, but not always; limbs stiff, though movable and cold; deglutition impossible, and complete aphonia. Percussion of the chest produced a clear resonant sound, and auscultation revealed no respiratory murmur; the chest was well filled with air. The heart sounds and impulse were normal, though slower than usual. Pulse full, regular, and slow, averaging sixty-five to the minute. She would seldom lose consciousness, knowing everything that was transpiring around her; but could not speak or motion to her attendants.

These paroxysms would last from two to eight or ten minutes, and be suddenly relieved by a violent and successful effort to restore respiration, when she would sink back utterly exhausted, with increased pulse, sometimes palpitation for a short time, slight headache and fulness in the head.

Between these attacks she was exceedingly weak, suffering with pains in the limbs, and difficulty in moving them; the appetite was fairly good, bowels regular; and the menstrual period normal and regular during her entire illness. Any nervous shock, excitement, or worryment would aggravate her troubles.

In regard to her family history, I was informed that her mother had had "bad spells" for several years before she died, and that my patient's daughter, eighteen years old, had fits; so I concluded this trouble was hereditary.

The remedies principally relied on before I saw her in a paroxysm, were bell., zinc. met., hyos., sepia, and agaricus. With these I was enabled only to relieve the severity of the attacks and to lengthen the time between them; but this was not satisfactory as the results were not permanent, and I was not curing my patient.

After making a careful examination while she was in a paroxysm, I decided that naja was the remedy, and gave the 3x in water, a teaspoonful every three hours. Improvement began immediately, and continued until she was entirely free from the paroxysms.

In the symptomatology of naja we have—mind, sad and serious, brooding over imaginary wrongs, forgetful, loss of consciousness; confusion and dulness in the head; eyes fixed and staring, wide open, insensible to light; loss of the sense of vision; jaws set, mouth open; taste, bitter and metallic; loss of speech, with a sense of choking; deglutition difficult or impossible; respiration very slow, scarcely perceptible, labored and difficult, gasping for breath; pulse slow; sudden prostration of strength; extremities cold, icy coldness of feet and limbs.

Naja was continued, varying the potency from 3x to 200, with longer intervals between the doses, as improvement continued; the attacks grew steadily less, and ceased altogether by the 28th of May. Up to the present time she has been perfectly well.

OCULAR SYMPTOMS ACCOMPANYING LA GRIPPE.

BY W. H. BIGLER, M.D., PHILADELPHIA.

(Read before the Philadelphia County Homœopathic Medical Society.)

LIKE the convenient term “malaria,” La Grippe is fast becoming a medical scape-goat, compelled to bear the responsibility of many an ailment, its connection with which is perhaps possible, but in very many cases hardly probable. Thus in the case of diseases of the eye, we have many, referred at least by the patient, to an attack of the grip, while nothing in the symptoms attending it would have led the physician to anticipate anything like them.

We will endeavor to see what symptoms during the attack would be likely to cause later trouble, and which, therefore, should receive special attention.

In my experience of this year's epidemic, the number of cases

coming under my treatment with pronounced symptoms of influenza or coryza, has been comparatively small. Whether the cheap instruction furnished by the daily press has enabled the laity to pass through the first stage without professional aid, or whether the upper air-passages were in general less affected than in previous years, I cannot say, but the majority of my cases have seemed to commence with laryngeal and bronchial irritation, while the nose and eyes have escaped severe implication.

Where coryza has been present, and the eyes have suffered in connection with it, it has been in the common form of catarrhal conjunctivitis, readily traceable to extension from the nasal passages by continuity of tissue. It usually proved either very amenable to treatment, or more probably self-limited, and in no case of mine showed any tendency either to assume a chronic form, or to extend to the ciliary border, or to cause closure of the puncta lachrymalia, as is so frequently the case after measles.

The cases of superficial keratitis which have occurred during, or immediately after, the grip, I would not be inclined to ascribe to it; more likely, seems to be a causal connection between it and the cases of phlyctenular conjunctivitis and episcleritis, which have presented themselves, while the occurrence of rheumatism with and after the grip, renders it possible that some of the cases of iritis may be rheumatic in their origin, traceable to the prevailing epidemic influence.

Although irito-choroiditis and retinitis are possible consequences of epidemic influenza, nothing further advanced than hyperæsthesia of the retina has presented itself to me. This condition corresponds to the general hypersensitiveness of the nervous system found so frequently with this disease, and manifested by an unusual intolerance of pain, and by unwonted complainings. We are required to diagnose between this state of the eyes and conjunctivitis, or superficial keratitis, or incipient iritis. The absence of any discharge, except tears, of any cloudiness of the corneal surface, and of any pericorneal injection, is sufficient to enable us to make this distinction, while the desire to keep the eyes closed, the general flushed weak look of the eyes, *without localized injection*, will confirm our diagnosis.

The muscular debility, so characteristic of the grip, finds its expression in both the internal and external muscles of the eye.

The internal, the ciliary muscle, having become weaker, may lose in part, or altogether, its power of producing accommodation changes, and we find latent hypermetropia becoming manifest; presbyopia

suddenly making its appearance, and the use of the eyes without glasses attended with all the symptoms of an hitherto unknown eye-strain.

The external muscles of the globe participate in the general muscular weakness and painfulness, and we have pain on moving the eyes in the orbits, soreness of the balls, and sensitiveness to pressure. The painful aching of the balls so frequently accompanying the excruciating headache with which an attack of the grip is ushered in, is no doubt muscular, and corresponds to the "aching all over" so characteristic of the epidemic.

Diplopia, and even manifest strabismus, would not excite surprise, nor cause anxiety, since they would seem natural extensions of the disease, and would probably prove very tractable to treatment, both by drugs and by restorative measures.

Of all the above-mentioned conditions, I consider it of the most importance to emphasize the last two, since their symptoms are more obscure, and the underlying cause more apt to be overlooked than in the case of the others. The treatment and cure of such cases are best left to the general practitioner, the careful and considerative specialist being called in merely to palliate, *for a time*, by the weakest satisfactory glasses the annoying asthenopia.

While I have not been able to present anything new on this subject, I have endeavored to present it in such a way as will suggest as profitable topics for discussion the questions:

1. Whether, and how far, the ocular symptoms have proved of sufficient severity as to modify the general treatment; and
2. Whether, and to what extent, the ocular symptoms have afforded reliable indications in the choice of remedies?

A CASE OF TANSY POISONING.

BY HAVARD LINDLEY, M.D., BALTIMORE.

TANSY is an herb of such frequent use in the form of "tansy tea" or "tansy bitters" that one would expect to find more data concerning it and its antidotes, when taken in too large quantities, than I have been able to do. In fact very little is said about it, and yet country people who "know all about herbs" use it constantly. It is steeped in whisky and taken as a "bitters" by the men, and hardly

a country bar-room can be found that can't show its "tansy bitters bottle." Women all over the country use it as a "tea" to help regulate their "sickness," or in larger and stronger quantities to produce abortion.

The *United States Dispensatory*, in speaking of tansy or *tanaceum*, says: Taste, warm, bitter, somewhat acrid and aromatic; odor, strong, peculiar and fragrant, but much diminished by drying; medical properties, aromatic bitters and an irritant narcotic.

It has been recommended in intermittent hysteria and amenorrhœa, and as a preventive of arthritic paroxysms, but in this country is little employed for any purpose in regular practice. The seeds are said to be effective as a vermifuge. A fatal case of poisoning with half an ounce of tansy oil is reported in the *American Medical Magazine*, November, 1834. Frequent violent clonic spasms were experienced with much disturbance of respiration. The action of the heart gradually became weaker till death took place from its entire suspension. Two other fatal cases have been reported, one from a fluidounce, one from only a fluidrachm. In both cases death followed speedily, preceded by coma and violent convulsions. In two of the three cases referred to the oil was taken to produce abortion, but no such effect followed in either. Dr. Pendleton records a case in which death resulted in a negress of twenty-one after a considerable quantity of strong decoction of tansy had been taken.

The *Journal of Pharmacy*, 1870, page 321, reports a case of a girl who, having taken half an ounce of the oil with the intention of producing abortion, was seized with convulsions, with foaming at the mouth, followed by dilated pupils, frequent and feeble pulse. Recovery took place after vomiting maintained by warm drinks, sassafras and a dose of castor oil.

In Burt's *Physiological Materia Medica*, tansy is claimed to be an emmenagogue, but, judging from clinical experience in reported cases, even where taken in quantity sufficient to produce death, it has not proved so.

The same author also says: "The greatest use of tansy is found in poisoning from ivy or sumac, used externally in decoction, and as tea internally it will be found an *absolute specific*. No known remedy can take its place."

This may be valuable; and as he gives no antidote for tansy, by reversing his proposition we may find one in *rhûs* or *sumac*.

Jahr's *New Manual*, the only homœopathic authority I can find who gives tansy, says: Great mobility, extraordinary motions,

strange gesticulations, drawing up of the feet and extending them again suddenly (without the least pain) for half an hour, several times after taking repeated doses of the medicine. In a boy of 12 years, from taking half an ounce of the extract, no remedy or antidote is given or suggested.

On January 26, 1892, I was called in haste to see the child of R. C. Chase. The child was a boy of 5 years, strong and hearty, and had had but little sickness during his life. I found him in a profound stupor, from which he could not be aroused. His breathing was hurried and irregular, teeth clinched, with a little foam on lips, heart action irregular and weak, pupils enlarged and insensible to light. The limbs were cold and perfectly relaxed. On inquiry found that he had seen his father take his "morning bitters" from a bottle in which had been poured a lot of Scotch whisky and some Benedictine and a lot of tansy soaked in it. As near as I could find out the child had taken from a gill to half a pint of this mess. After taking it he was very lively, wanted to black his shoes, etc., for half an hour, then suddenly stopped and said he was sleepy, and in five minutes was in a stupor from which he was partially aroused by the application of cold water to his head, and drank a glass of milk, immediately going off again. His father then sent for me. I tried to provoke vomiting by the administration of warm salt and mustard water, salt on tongue, snuff on tongue, and, finally, by five grains of sulphate of zinc, all without effect. The child could not, or would not, swallow (the former I believe). I then procured the assistance of Dr. Eldridge C. Price and a stomach pump, but the latter was of no use. (I have since found out that the child had had no breakfast, and the stomach being empty the fluid was rapidly taken up.) By this time some two hours had elapsed and the little fellow was slightly recovering the ability to vomit, as was shown by a retching, when Dr. Price tried to introduce the stomach tube. He threw up a small quantity, probably a gill, of viscid mucus smelling strongly of the drug.

The heart action was becoming weaker as the stimulation of the whisky passed off, and thinking he had had quite enough of alcohol I administered camphor spirits, ten drops, in ten teaspoonfuls of water, a spoonful every fifteen minutes; I applied the spirits to the abdomen externally and injected nearly a pint of black coffee into the rectum. Hot water bottles were also applied to the feet and arms. Under this treatment he rapidly improved, the breathing became natural, pulse more regular and stronger, and in about an

hour I considered him out of danger. He was "stupid" for twenty-four hours after this, had no appetite for two days and slept a great deal, complained of cramps in the abdomen, which were relieved by the application of cloths wrung out of hot water. His bowels did not move for three days. His recovery was complete, and he is "bright as a button" now. I report this case hoping it may help some "brother in need" who may look in vain for a helping suggestion (as I did) when summoned in a hurry.

·SYMPHYSEOTOMY.

BY PROFESSOR A. PINARD.

(Translated from the *Annales de Gynécologie et d'Obstétrique*, February, 1892, by J. Nicholas Mitchell, M.D., Philadelphia.)

AT the present time, when we find ourselves in the presence of a woman in labor and having a contracted pelvis, and we have proven it may be, only by measurements, or it may be after the fruitless employment of the forceps, the impossibility of the expulsion or extraction of the fœtus by the natural passages, we are reduced to choose between the two following methods to deliver her, either to crush the head and terminate the labor by the natural passages, or to practice the Cæsarian operation.

When the child is dead the situation is simple. The indication for crushing is positive, accepted by all and, thanks to the basiotribe, that marvellous instrument for which we are indebted to M. Tarnier, cephalic embryotomy is done with ease and safety. All who have handled the basiotribe or have seen it handled will agree with me that basiotripsy is often an easier operation than an exact application of the forceps at the superior strait, and that the prognosis for the mother is equally favorable. The results which I published in 1887, those which I have been able to note since that time, leave me without any doubt on that subject.

The situation is altogether different when the child is living. Crushing is debatable and much disputed by the partisans of the Cæsarian section. While the French obstetricians, with few exceptions, relying on the results of basiotripsy, sacrifice the child in every case to save the mother, a large number of foreign obstetricians give preference to the Cæsarian operation *when the condition*

has not been compromised by attempts to extract by the natural passages. What are the results of these different methods of procedure? In fifty women in good condition on whom basiotripsy was practiced, the child being alive, we have:

Women recovered,	50
Children sacrificed,	50

In twenty-eight women in good condition operated by the Cæsarian section we have, according to the most favorable statistics, those of Leopold (up to 1890):

Women recovered,	25
Dead,	3
Children saved,	28

Therefore, yet to-day, notwithstanding the considerable progress realized since fifteen years, in the presence of a case such as I have described at the outset of this discourse, we are reduced either to practice an operation which saves the mother as surely as it kills the child, or to perform an operation which saves the child at the risk of the mother's life.

Shall we rest always facing this cruel alternative? Shall we be condemned yet for a long time to this pain, which it is necessary to have endured to comprehend, of killing living children or of making the mother run such formidable risks as the Cæsarian section? I hope not, gentlemen; I believe that this fatality may disappear, thanks to an operation—*symphyseotomy*, conceived in 1768 by one of our fellow-countrymen, a student of surgery, Sigault, who operated for the first time and with success in 1777 upon the wife of a soldier named Souhot.

This astonishes you, I understand; and you ask of me without doubt wherefore I lay the foundations of such great hopes on the reviving of an operation that some among you know has been abandoned for so long a time, and others are ignorant almost of the name.

It is this, gentlemen, which I desire to explain to you to-day.

Although I neither could nor wish to make for you here a complete history of the section of the symphysis pubis, it is impossible for me not to recall the leading features, for thus is it that I can only hope to make you understand the causes of the greatness, the decadence and the resurrection of this operation.

So, as I have just told you, it is to Sigault that belongs the

merit of the conception and application of symphyseotomy, and never, as some have sought to insinuate, to Séverin Pineau. Poorly received at its *début* by the Academy of Surgeons, but practiced with success by its author in 1777, the new operation soon had a great reputation and provoked an extraordinary enthusiasm. The Faculty of Medicine did not believe that in having a medal struck off in his honor that they had too highly recompensed Sigault, who was looked upon by many people as a benefactor to humanity. As always, when a new operation is extolled, cases where symphyseotomy was supposed to be applicable multiplied themselves at the desire, in Paris, in the provinces and abroad. But soon a reaction occurred and one could assist in an ardent dispute between the symphyseotomists and Cæsarianists, a dispute in which the accoucheurs of the world took part. Among the bitter enemies of symphyseotomy I regret to be obliged to mention in the first rank, Bandelocque. Having, in 1776, sustained a thesis in which he announced himself against Sigault's operation, he never wished to review his first judgment. Perhaps this was the cause of his persistence in what I consider an error. However it may be, Bandelocque, who had nevertheless made a number of experiments with cadavers and some very judicious criticism of them, said, in summing up, that when women operated by symphyseotomy should die, it was indisputably the operation alone which should be incriminated; that they found at autopsies lesions as numerous as frightful, so that a physician, that poor M. de Mathiis, assisting at the autopsy of one of his operations, "at the sight of so much disorder was so agitated that he became sick and fell in a syncope." As to the women cured, perhaps some of them, said Bandelocque, have not been operated on; and in those cases where he could not deny the operation, he affirmed that it had been done unnecessarily. The accouchement would have taken place spontaneously, as was evidenced by the signs of the immaturity of the children.

In short, the operation recommended by Sigault could not give good results, since from his experiences Bandelocque affirmed that the sacro-iliac symphysis would be lacerated after the separation of the pubic bones of less than two inches and a half, and that notwithstanding this separation the increase in the antero-posterior diameter is insufficient to allow the child to pass.

The anathemas of Bandelocque were repeated by Mme. Lachapelle. Also, although Antoine Dubois had operated the woman Delaplan for the second time, and notwithstanding the judicious

pleading of Gardien in favor of symphyseotomy, the operation was not slow in disappearing from the practice of French accoucheurs. P. Dubois and Désormeaux almost condemned it. If Velpeau, Jacquemier, Cazeaux did not repel it absolutely, and even thought that it might have its indications in some cases, yet they did not practice it.

Stoltz, although he had invented a new method of symphyseotomy, preferred the Cæsarian section. It was the same with Tarnier, who, nevertheless, wrote in the text which accompanies l'Atlas de Lenoir, M. Sée and Tarnier, "that it is, perhaps, not audacious nor hasty to think that some day symphyseotomy will be the complement of premature labor." I will add, finally, that M. Bouchacourt, who, in the article "Symphyseotomy," of the *Dictionnaire Encyclopédique des Sciences Médicales*, a very interesting article, whose reading I recommend to you, reports that he had made with M. Polosson experiments in this subject and shows himself favorable to the operation; especially depending on the results obtained in it by the school in Naples, as he had never had recourse to it. In Germany, E. G. J. de Siebold has formulated, somewhat after Bandelocque, this summing up of symphyseotomy: "There is," says he, "a great truth in the judgment of Bandelocque, who says that every time they have saved a child they have killed the mother, or when they have saved the mother they have killed the child; when the two individuals have been saved the operation was unnecessary." And, further on, in ending the consideration of the operation, he adds: "Experience and time suffice to-day to permit one to come to a final judgment; for all those who are not blind it remains no more than a historical curiosity, and it is to it that one can apply that valuable proverb: 'Felix quem faciunt aliena pericula cautum.'"

Zweifel wrote, in 1889: "The idea of it, even, is false." Fehling says: "When the woman only consults one at term, the conservative Cæsarian operation (Sänger's operation), if the child is living, and craniotomy if it is dead, are worth much more than symphyseotomy. I am on this point in accord with all German, French and English accoucheurs." Winckel (1889) condemned it equally. In the fourth edition of Fritsch (of Breslau), 1888, there is no discussion of symphyseotomy, and in the tenth edition of Schröder, reviewed by Olshausen and J. Veit, the word even does not exist in the table of contents. The same reprobation on the part of English obstetricians.

In Italy, on the contrary, symphyseotomy, which has been since its *début* acclaimed as a blessing from heaven, took root. It has been practiced a number of times since the beginning of the century, and since a number of years almost exclusively by the Neapolitan school. The results obtained have been published several times by Professor Morisani (Congrès de London, *Annales de Gynécologie*, 1881, and *Annali de Obstetricia*, 1886), who has kindly sent to me the results obtained since 1887 up to this present day, and with which I will make you acquainted presently. I address my most sincere thanks for this matter to the Director of the Obstetrical Clinic of Naples.

I will not stop to discuss for the moment either the causes which have made symphyseotomy to be abandoned and condemned by the greater number of obstetricians or the reasons wherefore the Obstetrical School of Naples affirms that it is a useful, beneficent operation and entitled to hold a large place in obstetrical operations. I will only recall to you that the introduction of antiseptics has rendered possible and harmless a number of operations sufficiently grave, if not always mortal, and that symphyseotomy seems to be of the number.

Under these new conditions the main point of the discussion rests entirely on the solution of the following questions:

1. Can one obtain by symphyseotomy, without grave lesions, a notable enlargement of the pelvis? What may that enlargement be?
2. Is symphyseotomy within the power of all accoucheurs, and how should it be performed?
3. What are the consequences of the operation relative to the uniting of the pelvis, to the upright position, to walking and to later pregnancies?

1. As to the first question, the results published by Bandelocque and by those who, since Bandelocque, have sought to elucidate this question, appear absolutely contradictory. For the one symphyseotomy could only gain some millimetres to the antero-posterior diameters. For the others these diameters are increased markedly. But even those who concede this enlargement think that it cannot be obtained without tearing the ligaments of the sacro-iliac symphyses without a veritable dislocation with formidable consequences. Let us try to explain these contradictions, and let us seek the truth by the aid of those ancient documents, and by some experiments that I have made with the collaboration of Professor Farabeuf and of my chief of clinic, Dr. Varnier. Without drawing any conclusions,

let us see, first, this cut made following the plane of the superior strait of a pelvis of 10 c. 8 belonging to a woman dead from nephritis nine days after an accouchement at term, and which M. Labadie-Lagrave, physician to the Maternity, and M. Gouget, his interne, have graciously put at my disposal (Figs. 1 and 2.) By means of a separation of the pelvis of six centimetres, the pelvis of 10 c. 8 has become one of 12 c. 4; that is to say, the antero-posterior diameter has gained 14 millimetres. The sacro-iliac articula-

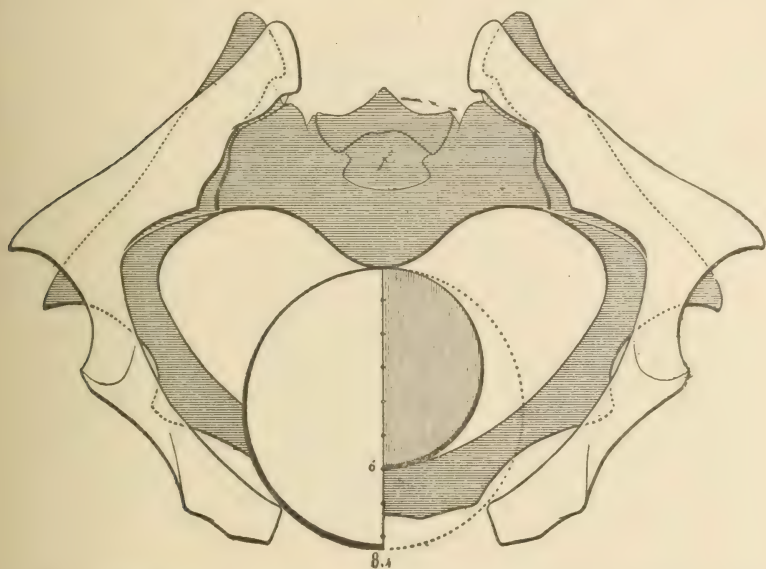


FIG. 1.—Section parallel to the plain of the superior strait of a pelvis very contracted, having a sacro-pubic diameter of six centimetres, represented gray before the section of the symphysis and white after the separation of sixty millimetres permitted by that section. The diameter of the white sphere secured by the separated pelvis is to the gray sphere adjusted to the intact pelvis as 84 : 60. The volume of the white sphere is to the volume of the gray sphere :: 310 : 113, almost threefold.

lation is gaping in front; the powerful posterior ligaments are intact and do not suffer from the separation of the pelvis more than they can stretch; the thin anterior ligament which resists the stretching is not even torn, but simply stripped from the anterior face of the ilium. I take away the inserted piece of wood which fixates the separation and I shut up the pelvis (Fig. 2); the surfaces of the sacro-iliac articulation approach one another, and it is necessary to look at it closely to discover traces of the separation. See also that other cut which interests the surgeon as much as the ob-

stetrician. It has been less happy than the preceding ; the saw has notably swerved to the left for a plane of the superior strait. You can see, notwithstanding a separation of 3 centimetres, the anterior ligaments of the sacro-iliac symphyses are not even stripped off. Besides, gentlemen, this is a pelvis of an old woman, dead without any puerperal conditions.

So, in these two pelves, one of which is vitiated and the other

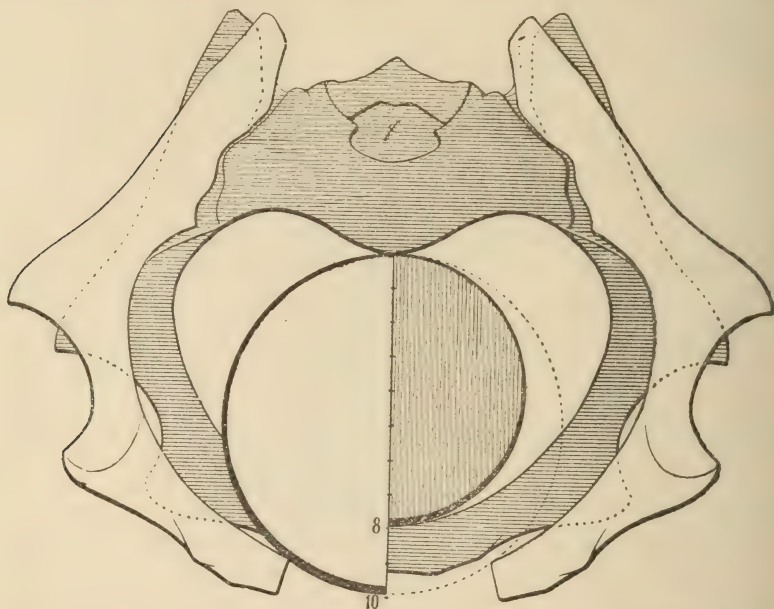


FIG. 2.—Section parallel to the superior strait of a pelvis moderately contracted, having a sacro-pubic diameter of eight centimetres—represented gray before symphyseotomy, white after the separation of sixty millimetres permitted by that operation. The diameter of the white sphere secured by the dilated pelvis is to the diameter of the gray sphere adjusted to the intact pelvis as 98 : 80. The volume of the white sphere is to that of the gray sphere :: 488 : 267, almost double. In other words, a fœtus of 3000 grammes will be smaller for the cut pelvis than a fœtus of 2000 grammes for the intact pelvis.

normal, one of which belongs to a non-puerperal, aged woman and the other to a woman who died in child-bed, you can find proofs almost identical to persuade you : 1st, that enlargement is possible, that it is notable ; 2d, that kept within useful limits it is made without any other alterations of the pelvis than a stripping off of the anterior ligaments of the sacro-iliac symphysis.

In order to estimate the enlargement of contracted pelvis by means of a separation of the pubic bones of six centimetres, it will

suffice for you to look at the two accompanying figures (Figs. 1 and 2), which have been constructed by M. Farabeuf to illustrate mathematically the results that we have obtained and that we should always obtain. You will see there, that which Bandelocque had already proved; an enlargement is much more considerable in proportion as the contraction is more marked. And the suggestive explanation which accompanies them will complete my thoughts. I leave aside other secondary points which are for study. It suffices me for the present to have shown you what symphyseotomy can give you without great damage to the articulation.

2. The majority of those who have done this operation look upon it as relatively easy whatever method of operation was carried out. M. le Dr. Spinnelli, senior assistant to Professor Morisani, has kindly offered not only to give me the most complete information of the different methods employed in Italy, but also to perform before us the operation on the cadaver in the manner employed at Naples. I addressed to him my thanks for this offer, for fervent apostle of symphyseotomy, he is well fitted to captivate our convictions. I believe that the method of operating can be simplified and made more certain; I am convinced that in the majority of cases symphyseotomy will be easy; that one can divide the symphysis without fear of lesions either to the bladder or to the peritonæum and that it is not necessary to have at one's disposal a collection of complicated instruments. Here is what seems to me reasonable:

I do not reject entirely the osteotomes ordinarily employed; I believe even that it is wise and prudent to have them within reach. But I judge that a simple bistoury with a short, strong blade, sufficiently thin, will be sufficient and preferable in the greater number of cases.

Having taken all antiseptic precautions and having all the surgical and obstetrical instruments ready, I would place the woman in the dorsal decubitus perfectly flat on a bed of a height sufficient for me to be able to look perpendicularly down along the median line upon which to make my incision. I would place myself on the right of the patient, drawn up very close to me.

Having shaved the pelvis and marked the sterno-clitoris line by a string or by a coloring liquid, as the case may be, I would incise the teguments and the fat on the pubic regions carefully along that line, holding my bistoury inclined, and advancing strictly in the vertical median plane.

An incision of 8 to 10 centimetres would seem to me to be suffi-

cient ; it would stop above the clitoris and there only deviate slightly to escape that organ and its vessels.

Then I would separate the rectus muscles in the superior part of the wound to permit the entrance of a finger into the pre-vesical cavity to protect the bladder and to feel the swelling (*le bourrelet*). Then having again taken careful notice of the median line, I would incise the symphysis above and below, in front and behind, by many cuts of the bistoury.

If I may judge from the cadaver, when the symphysis is cut, the pubes separate themselves slightly of their own accord. If necessary I would aid in the separation by having two assistants draw upon the thighs.

I would reserve the sub-pubic ligament for the last ; I would not carry the point there, but with reserve, trying at first to force it with the finger. I would not stop until I could pass the finger between the pubes through their entire height. And even then I should wish, before any obstetrical operations, to assure myself by producing a prudent abduction of the thighs, that the section was complete, that there remained nothing in advance which the foetus would have to overcome by violence and at the peril of its life, that is to say until the pubes could be separated to the extent of 4 to 6 centimetres. After having thus assured myself that the pubes were free, that the anterior sacro-iliac ligaments would permit of a marked separation, I would fill up and cover the wound antiseptically (temporary dressing), and would again become an accoucheur.

3. This being said, I arrive at the third question : "In what condition is the union of the pelvis observed and effected after symphyseotomy. We know already, by observations sufficiently numerous, that after a rupture of the symphysis, either spontaneous or accidental, during labor that reunion is the rule. I have had for my part a good opportunity to observe this. On the 25th of December, 1883, while making an application of the forceps in my service at Lariboisière, to a woman who had a contracted pelvis, I heard at the moment, when with a single finger, I was performing a movement of rotation to the head and to the instrument, a loud crack. After completing the extraction and finding no depression in the head of the child, which was in good condition, I touched and recognized with fright that the symphysis was fractured and that I could place two fingers in the separation between the pubes. Six weeks afterwards, without the application of any retaining apparatus, she left the Maternity walking as well as she had done before

her confinement. I may add that becoming pregnant for a second time, this woman, who had a well marked contraction of the pelvis, was delivered at term spontaneously.

I was then already confident to a certain degree and this observation had given me much to reflect upon. Furthermore, I knew that Antoine Dubois had performed symphysiotomy on a woman who submitted to it for the second time and nevertheless was perfectly restored. But the results very recently observed in Naples, and reported in detail by Morisani, do not permit of further doubt. After symphysiotomy the union of the pelvis takes place and according to the information which has been given me by Drs. Spinelli and Professor Morisani, in a lapse of time even quite small, about a month. It is evident that it is necessary to enforce, during cicatrization, the immobility of the pelvis by the aid of a plaster bandage, by a mechanical bandage, by a *gouttière de Bonnet*, etc. This is my answer to the third question.

If then these three replies are exact, if the section of the pubes constitutes a comparatively easy operation, if a separation of six centimetres gives an enlargement such as I have announced, if the consecutive consolidation of the pelvis does not fail, I ask myself why we should leave it to the school at Naples to enjoy alone its benefits.

Is it not time to struggle and react against the anathema formulated by Bandelocque? Are we not authorized at this present time with the facts at our disposal to revise the judgments of our ancestors?

Is it that the bad effects attributed to symphysiotomy are oftener due to infection, and not to the operation itself? Is it that the Dubois, the Desormeaux, who, without condemning symphysiotomy, did not practice it, had taken this view of the matter because they knew how dangerous all operations performed during labor were? Then who knows if the basiotribe itself would not have been condemned and cried down if it had seen the light at the same time as the operation of Sigault?

Are the numerous successes of the Cæsarian section due exclusively to the modifications introduced, very happily, I acknowledge, by Poro and Säger? Assuredly not. They are due above all things to antiseptis. Very well, can it not do for symphysiotomy that which it has done for the Cæsarian operation? Have not our colleagues at Naples shown us the example? Why! when I received yesterday statistics from Professor Morisani, in which I read that in

12 symphyseotomies operated at the obstetrical clinic in Naples there were 12 mothers saved and 11 living children, ought I to do nothing to follow such an example and to obtain equal results? Such is not my opinion. And if I do not deceive myself, symphyseotomy, which had the misfortune to be introduced by a man without authority in obstetrical practice, and who could not but compromise it, depending to-day upon antisepsis, being enlightened by the more exact knowledge which we possess about contracted pelves, guided by the certainty of our methods of exploration, profiting by the improvements of our technique in operating, will become, as M. Tarnier has predicted, the complement of premature labor in many cases and will be substituted for embryotomy and the Cæsarian section in many others, leaving to these a very limited field where they will reign alone without rivalry.

And I wish earnestly not to deceive myself, for if I am in the truth the lives of many women and many children will be saved, and accoucheurs will no more have to impose upon themselves the torment of crushing infants full of life whom they have the mission to save.

THE INFLUENCE OF ALCOHOLIC DRINKS ON THE URINARY SEDIMENT OF HEALTHY PERSONS.—Dr. Glaser has examined the urine of persons who were in good health after the use of alcoholic drinks, employing the centrifugal apparatus of Steinbeck. Beside the formation of uric acid and calcium oxalate crystals the most important findings were an increase in the number of leucocytes and the appearance of cylinders and cylindroids. The increase in the leucocytes was so constant that the writer was able to decide as to a preceding excess in drinking. With the continued use of alcohol the increase was so great that one would think one had a specimen of urine with pus in it. Hand in hand with this went the augmentation of the number of cylinders. He concludes as follows: 1. Alcoholic drinks, even in moderate quantities, act as irritants to the kidneys, causing the emigration of leucocytes and the formation of cylinders; further, they favor the excessive production of crystals of uric acid and calcium oxalate. This is either due to the increased metabolism of the tissue or an alteration by the alcohol of the relations of solubility of the salts of the urine, so that the oxalate of lime and uric acid are precipitated. 2. This action, after a single indulgence, does not extend over thirty-six hours, and with continuous use is cumulative.—*Deutsche Med. Wochenschr.*, No. 43, 1891.

ON SUBCUTANEOUS TENOTOMY OF THE SPHINCTER ANI IN THE TREATMENT OF FISTULA.—G. A. Wright proposes to avoid the tedious after-course following the ordinary operation of laying open an anal fistula by the following method: A sharp pointed tenotome is introduced about three-quarters of an inch to the left of the middle line just in front of the coccyx. When the point is felt under the mucous membrane from inside the rectum, the knife is tilted and made to divide the sphincter by cutting toward the skin. If preferred, the sphincter can be divided at some other point. The fistula is then scraped out thoroughly. In this way the indications for any operation for fistula are fulfilled, *i.e.*, to quiet the contractions of the sphincter and to freshen the granulating surface and allow the wound to heal. Of nine cases operated there were five successes, three failures and one patient was lost sight of, but was apparently well.—*British Medical Journal*.

CORRESPONDENCE.

THE INSTITUTE SESSION OF 1892.

EDITORS HAHNEMANNIAN MONTHLY:

The annual session of the American Institute of Homœopathy will be held in Cornwallis Hall, Washington, D. C., beginning on Monday, June 13th, and continuing until Friday, June 17, 1892. Monday afternoon will be devoted to preliminary and routine business, and in the evening the President's address will be delivered and the memorial service held. (See *Transactions* of 1890, p. 63).

The proprietors of Willard's Hotel, the Ebbitt House and the Riggs House have contracted with the committee of local arrangements for a uniform rate of three dollars per day to the physicians attending the meeting and to the friends accompanying them. Private bath-rooms or parlors to be charged for extra at the usual rates. Rooms, meals and attendance to be first-class in every respect. The local committee will establish their headquarters at Willard's, and will maintain a bureau of information and registration, at which all persons attending the sessions are requested to register. The committee requests that all engagement of rooms at any of these hotels be made through their chairman, Dr. J. B. G. Custis, or their secretary, Dr. William R. King.

The preparatory work of the bureaus is being prosecuted with more than usual vigor and with special efforts to secure an intelligent and profitable discussion of the papers. Essayists who wish their papers well discussed should place duplicate copies in the hands of the appropriate chairmen at least one month before the meeting.

The session of 1892 presents some special claims to the support of all Homœopathic physicians. To keep alive the prestige and influence gained at the meeting of the International Congress; to encourage the growth of Homœopathy in the Southern States; to present a strong front to the governmental officials assembled at Washington; to antagonize the schemes now taking shape for the subversion of the professional liberty of the physicians practicing in and around our National Capital; to take action respecting the boycotting of Homœopathic physicians by life insurance companies; to further increase the numerical strength and influence of our National Society, and to prepare for the proper display of our power and importance as a profession to the peoples who will visit our shores during the Columbian Exposition. These are some of

the motives and objects that should determine and secure a very large and enthusiastic meeting of the Institute at Washington next June.

The secretary's annual circular, to be issued in May, will contain information concerning railroad rates and facilities and a complete programme of the business of the session. Any physician failing to receive a copy can obtain it on application. Membership in the Institute is open to all physicians in good standing. A blank application will accompany the annual circular. Admission fee, \$2.00; annual dues, \$5.00, entitling the member to the annual volume of *Transactions*.

PEMBERTON DUDLEY, M.D.,

General Secretary.

Fifteenth and Master Streets, Philadelphia.

WHICH CURED?

EDITORS HAHNEMANNIAN MONTHLY:

A PHYSICIAN was seen several months ago, suffering from a specific urethritis at its height. The symptoms were typical and gonococci were found in abundance. Cannabis sativa was prescribed, in the absence of special indications, with frequent and long-continued soakings in hot water. This was to be followed by a permanganate of potash wash, as soon as the acute inflammation *began* to subside. In a few days he developed an attack of grippe, the symptoms calling typically for gelsemium; suffused face and eyes, characteristic headache, chills up and down the back, aching all over, temperature 103°, etc.; in short, an unmistakable picture, which was quickly cleared up while taking the drug. With the subsidence of the intercurrent trouble, the discharge rapidly decreased and dried up in a few days. During this time an occasional dose of thuja was taken.

In these days of antagonism between the micro-organisms of cancer or syphilis and erysipelas, and after the observations of the power of one exanthem to shut out or postpone another, the question arises, which cured, the grippe or gelsemium, or was it a coincidence? The drug was certainly *not* indicated when the patient was first seen, the fully developed urethritis gave no local or systemic indications, and promised to run a typical and very severe course, yet with the subsidence of, but not during the attack the discharge rapidly dried up without any special treatment, for no special curative action can be symptomatically attributed to the occasional dose of thuja.

WILLIAM B. VAN LENNEP, M.D.

EDITORIAL.

HOMŒOPATHIC TREATMENT FOR THE INSANE IN PENNSYLVANIA.

THE time is now ripe for the agitation of the project for the establishment of an asylum for the insane in the State of Pennsylvania where patients may receive homœopathic treatment. The question is to be handled in a wide-awake, common-sense, business-like manner to gain the confidence and support of the people of Pennsylvania and her legislators. The movement, to be a success, needs the best effort and faithful attention of the eleven hundred physicians in the State supporting homœopathy. The ability of men varies greatly,—some have one talent, some two, some five. The men with five talents need no urging; they are busy men, having all they can do, and yet they are the men who can always be depended upon to do a little more. These men will do their full share of the work necessary to accomplish the object desired. It is the men with one, two, or three talents who hold the key to the situation; and when their active interest is once fully awakened to the success of the enterprise, they will develop an ability that will push the project to a winning lead. Homœopathic physicians of Pennsylvania should remember that the movement for the establishment of an asylum for the treatment of the insane under the care of homœopathy needs them and their help, and that they, in turn, need an asylum for the care of their insane patients.

What is to be done now? *Think about it*, and if you conclude that it is fair and just to ask the State of Pennsylvania to provide an asylum where the insane citizen may receive homœopathic treatment, then *agitate* the question on every suitable occasion; agitate it at the clubs and local societies; discuss the subject earnestly; consider it on every side, and ascertain what will be the best method to forward the project and bring it to the favorable notice of the Legislature at its session next fall.

The next surest step to advance the movement will be to join the State society, attend its meetings in Philadelphia September next, and review together the status of the question. This will be your opportunity to contribute to the profession the fruits of your thought and experience on this subject, and lend the weight of your presence and name to the support of the movement to obtain simple justice for your patrons who may need homœopathic care for their insane.

Pennsylvania, at the present time, is coercing her citizens who desire homœopathic treatment for their insane into institutions controlled exclusively by the physicians and the methods of the allopathic sect in medicine,—a class favoritism that should not be tolerated longer. Now is the time to correct this injustice. There are three ways in which the object desired can be accomplished :

First. The profession to perfect its organization, secure the hearty co-operation of its friends, and prepare to petition the Legislature, individually and collectively, to grant a liberal appropriation to establish an asylum for the insane in the State of Pennsylvania, the patients of which are to be under the exclusive care of the homœopathic profession.

Second. To petition the Legislature to enact such laws as will secure a just recognition of the rights of the homœopathic citizens of the State, and secure to them an equitable distribution of public patronage by setting over, for the use of those desiring the homœopathic treatment for the insane, one of the asylums already established and maintained by the State.

Third. To follow the footsteps of the great asylum at Middletown, N. Y.; the profession and their patrons to contribute sufficient means to purchase a tract of land in some one of the counties of the State, start in a small way, apply for liberal appropriations for buildings and maintenance, and eventually take the steps necessary to make the asylum one of the public institutions of the Commonwealth. It is for the profession to decide which of the three plans is best, or what is better to adopt, to secure an asylum. At present, agitate the question, and *keep* agitating. To-day there is not an institution in the State of Pennsylvania, public or private, where the insane can receive homœopathic treatment.

THE AMERICAN OBSTETRICAL SOCIETY.

THE American Obstetrical Society will meet in session in the Hahnemann Medical College building, Broad Street above Race, Philadelphia, on Wednesday evening, April 20th, at 8 o'clock. A special invitation to attend is extended to all physicians who are at all interested in this special and important branch of medicine. A detailed notice of the meeting will be found on page 53 of the *News and Advertiser*.

DR. JOHN AUGUSTUS McVICKAR.

Dr. J. A. McVICKAR died in New York city, January 30, 1892, at eighty years of age. He came to New York a young man, and graduated at the College of Physicians and Surgeons in 1833, and was the first Professor of Obstetrics in the Medical Department of the New York University. In 1841 he became identified with the homœopathic school of medicine. Dr. McVickar was a physician of exceptional ability, a man of refined tastes and of lovely manners, highly cultivated in all branches of learning. He enjoyed a *clientele* second to none in New York city, up to the time his failing health compelled him to relinquish active practice, when about seventy years of age. Dr. McVickar was the father of the Rev. W. N. McVickar, D.D., the popular rector of the Church of the Holy Trinity, Philadelphia, and one of the active Board of Trustees of the Hahnemann Medical College of Philadelphia.

OLIVER P. BARDEN, M.D.

DR. OLIVER PARKER BARDEN died of pneumonia supervening an attack of la grippe, at his home in Tioga, Pa., January 25, 1892. The Doctor was born in Benton, Gates county, N. Y., October 1, 1839. He came to Mansfield, Pa., with his father when thirteen years old, and received his early education at the Mansfield Classical Seminary. In 1861 he enlisted in Company F, Eleventh Pennsylvania Cavalry for three years, serving his full term of enlistment. He returned home with health impaired and constitution undermined by the hardships and exposures of his army life, and from that time he was always a sufferer from asthma and chronic bronchitis, which led up to a serious heart trouble. After his return from the army he commenced reading medicine in the office of his father, the late Dr. William M. Barden, of Mansfield, Pa., and attended lectures at the old Hahnemann Medical College, of Philadelphia, where he graduated with credit in 1868. He located in Tioga, where he continuously resided until his death. As a practitioner, believing in the law of the master, he was pre-eminently successful. He was a man of quick perception and excellent judgment. He was a member of the Southern Tier Homœopathic Medical Association of New York, in which he had been secretary and treasurer for several years.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D.,

FRANK H. PRITCHARD, M.D., AND EDWARD M. GRAMM, M.D.

COMPLICATIONS OF INFLUENZA.—Dr. Schwaboth observed 63 cases of inflammation of the middle ear out of 89 cases which applied for treatment. In more than one half of the cases the condition in question was a simple otitis media acuta, in the others a purulent otitis; out of 78 cases there were 47 with simple otitis media acuta, and 31 cases of the purulent form. In general the course of this disease is benign. Several cases were followed by sympathetic neuralgia. Tympanic hæmorrhage was more frequent than is usual; the writer has observed 27 cases among 63 patients. This is the more astonishing, as, among 324 cases not due to influenza there were but 27 cases of tympanic hæmorrhage, i.e., to say that from 8 per cent. it rose to 43 per cent. during the influenza period. Professor A. Fränkel has observed, during the recent epidemic, five cases of gangrene of the lung. A sixth case was observed in the surgical ward of the hospital. The same condition was remarked in the epidemic of 1889. This gangrene has its point of departure in the small abscesses which are found in the small lobules attacked by pneumonia. The pus found here contains both streptococci and the bacillus of influenza, hence the condition is a mixed infection. Three of his patients, with pulmonary gangrene, died; one developed a pneumo-thorax, which was the immediate cause of death. In the second the necropsy revealed a vast pleuro-pulmonary abscess. In another, where one, though only a simple abscess was present, gangrene of the lung was found on surgical interference. Two patients with pneumonia, as a complication, relapsed eight and fourteen days after recovery. Once he observed typhoid fever and once again meningitis to follow influenza. Dr. Rosenberg has not only observed hæmorrhage from the tympanum to be a frequent occurrence in influenza, but has also remarked hæmorrhages from the upper portions of the air passages.

In one patient, who was quite uneasy over the frequent bloody sputa which he raised, the source of the hæmorrhage was found to be the tonsil; in a second case, the hæmorrhage came from the base of the tongue. Apparently in this epidemic, the tracheal and laryngeal mucous membranes were more severely attacked than usual.—*La Semaine Médicale*, No. 5, 1892.

HICCUGH TREATED BY COMPRESSION OF THE PHRENIC NERVE.—Dr. Selor was consulted by a little girl of twelve years, who had suffered for a year from incoercible hiccough, which set in every two minutes, interrupting sleep and eating and which was gradually exhausting the poor child. The father of the child had consulted a great number of physicians, who had prescribed every variety of antispasmodic in vain. The writer compressed the left phrenic nerve, between the two clavicular attachments of the sternocleidomastoid muscle, for three minutes, with his finger. Compression though quite painful, caused the cough to disappear entirely and permanently. Since then he has tried this method frequently in chronic hiccough, which has resisted all treatment. In some cases a few seconds suffice; others require several minutes. This simple procedure is a beautiful illustration of Brown-Séquard's theory of inhibition and at the same time a practical application.—*La Semaine Médicale*, No. 5, 1892.

INFECTIOUS BRONCHO-PNEUMONIA OF INTESTINAL ORIGIN.—Dr. Sevestre, who has made a study of this subject, terminates his work as follows:

1. Children who are fed upon injurious foods, may have, in consequence, fœtid diarrhœa and infectious enteritis from decomposition of the intestinal contents.

2. This may be followed by general infection and particularly symptoms of pulmonary congestion and broncho-pneumonia.

Dr. Le Sage, who has also investigated the subject and confirms the opinion of Dr. Sevestre, demonstrates the broncho-pneumonias following intestinal decomposition

offered are due to invasion of the lungs by the bacillus bacterinne coli. In five cases he observed pulmonary lesions during life, with accompanying splenic hypertrophy. In one case there were simple pulmonary congestion, of great intensity and presenting a brick-red appearance of the lungs, at the necropsy. The lung, thrown into water, floated, disgorged a certain amount of blood and resumed its primitive appearance. In some of these five cases, here and there in the lungs were found broncho-pneumonic foci, surrounded by a congested zone of lung tissue. In others they were undergoing suppuration. The bacillus bacterinne coli, was isolated from these foci and no other microbes could be found. Even in those cases where suppuration had set in only the same bacillus was discovered.—*La Semaine Médicale*, November 5, 1892.

PRIMARY ACUTE ENCEPHALITIS.—Professor Strumpell, of Erlangen, has made a careful study of this subject. While the primary inflammatory processes of the spinal cord are well known clinically, the analogous conditions of the brain, excepting purulent encephalitis, cerebral abscesses, are a closed book for us. The primary chronic forms of encephalitis, for example, those accompanying various psychoses, dementia paralytica, etc., require more elucidation. Amongst the acute inflammatory affections, an acute bulbar myelitis, as well as the cerebral disease, acute hæmorrhagic poli-encephalitis superior, and especially, the acute encephalitis of children, have been described. Strumpell emphasizes, with regard to the latter, the large group of cerebral infantile paralyses, which anatomic-pathological findings may be extremely various. One disease, the acute primary encephalitis of children, must be excluded. The clinical picture is as follows: The child, which is usually one-and-a-half to four years of age, and has, up to date, been perfectly well, suddenly becomes sick, is feverish, suffers from headache, and vomiting. After a few days, or even a few hours, violent cerebral symptoms set in, as, spasms, unconsciousness, etc. In the course of a few days, but after a longer time the acute process seems past. The child, then, is apparently well and hearty. Only a more or less extensive semilateral paralysis with accessory phenomena; contractures, retarded growth, athetosis, etc., remain, to persist the remainder of life unchanged. As an anatomical basis for this form of cerebral paralysis the writer excludes all chronic progressive processes and assumes the presence of cerebral hæmorrhages, emboli, and acute curable inflammation. In a certain number of cases cerebral embolism may be assumed to be the cause, yet there is no reason to regard all cases as of embolic nature, on account of there being no initial traumatism, cardiac insufficiency, etc. Hence in a number of the cases reported Strumpell assumes, with certainty, the presence of an acute, unlimited, progressive inflammation, with the subsequent formation of a cicatrix. The author does not regard the former name of the disease, acute poli-encephalitis, given on account of its analogy with poliomyelitis, as entirely covering the disease, for the focus of inflammation, besides being located in, the cortex, may as well be situated in the other portions of the brain. He therefore, considers the term "acute encephalitis in children" as better. The writer then communicates two very interesting cases of primary acute encephalitis in adults.

1. A young man, 27 years of age, hitherto entirely well, suddenly and without apparent cause, became sick, with grave brain symptoms. There was unconsciousness, paralysis with flaccidity of the muscles of the left side, arm and leg, while the facial nerve was uninvolved; the right arm and leg presented peculiar stroking and pushing movements. The tendon reflexes upon the right side were more exaggerated than on the left, the inguinal and cremaster reflexes were absent upon both sides. Fever, with a temperature of 39.3c. Already the next day the patient passed away, with continued unconsciousness and high fever (41.2c.) The post mortem revealed an extensive focus, including the greater portion of the centrum semiovale and the central ganglia, and a second, somewhat smaller, in the middle of the left hemisphere. The parts affected were of a yellowish gray and spotted appearance, the tissues were easily torn, greatly œdematous and filled with numerous punctiform ecchymoses. All the arteries were gorged with blood. No atheromatosis.

2. A laborer, 64 years of age, was found unconscious. Examination revealed: left-sided paralysis of the facial nerve, tongue and extremities. The cutaneous reflexes were weakened or wanting upon the left side, the patellar reflexes present upon both sides. Analgesia upon the left side. Temperature rose from 38 to 42.20 C. Pulse and respiration extremely rapid. The unconsciousness continued until the third day, when death took place. The necropsy brought to light

hæmorrhagic, inflammatory foci of softening, in the right parietal lobe and the occipital portion upon both sides; an old scar was found in the upper portion of the occipital lobe. The aorta was atheromatous. Both cases presented the same pathological changes in the inflamed portions; hyperæmia, collection of cells in the arteries, infiltrations of the tissues with round cells, which were in the course of disintegration, numerous capillary hæmorrhages, but no disintegration of the nerve substance.—*Norsk Magazin for Lægevidenskaben*, No 1, 1892.

THE ÆTIOLOGY OF TABES DORSALIS.—Professor Erb, of Heidelberg, has made an interesting study of this subject, based upon 370 cases of tabes dorsalis. He concludes as follows:

1. Direct heredity plays no part at all in the ætiology of tabes dorsalis.
2. The influence of a neuropathic entailment, nervousness of the family, single nervous diseases in the relatives, is not to be entirely excluded (28 per cent.), but it is of no great importance.
3. Congenital or acquired nervousness, together with syphilitic infection, may be an important factor in the production of the spinal disease.
- 4 and 5. Cold, exposure and privation, in non-syphilitic persons, are of no influence at all in the production of tabes. They are of grave importance in persons who formerly have had syphilis (31 per cent.), as they arouse the latent disease.
6. Sexual excesses are of some gravity (15.8 per cent.) In not a few cases, and nearly exclusively in persons formerly syphilitic, they are of decided influence.
7. Abuse of alcohol and tobacco plays a certain rôle (18 per cent.).
8. Traumatism, together with former syphilis and other injurious factors, seems to be of ætiological importance.
9. Overwork, excitement and emotional excitation may sometimes have as great an action as neuropathic entailment or nervousness.

Most of the tabes patients were soldiers and business men, a large percentage being bankers. Only one clergyman was among the number and he was syphilitic. Persons who were much exposed to cold, wet, etc., were not especially attacked. Syphilis he regards as the all-important factor in the majority of cases.—*Medicinische Neuigkeiten*, No. 42, 1891.

VARICOCELE AND NEURASTHENIA.—Dr. Wiederhold, of Wilhelmshöhe, Germany, claims, from observation of a large number of neurasthenic patients, to have found a certain connection between neurasthenia and varicocele. Keeping varicocele in mind as the primary cause, he has succeeded in curing many cases of extreme neurasthenia. It produces either the manifold picture of irritable, nervous weakness, observed especially in young people of healthy families, who have committed no important excesses, yet when they are put under greater mental strain than ordinary, they are unequal to the requirements and are incapable of further mental work. This very symptom is the one most frequently and prominently observed as characteristic. The patients would sit for hours before their books without being able to understand that which they had just mechanically read through. A letter would be begun again and again, to be torn up as unsatisfactory. Bodily debility would also frequently accompany these phenomena. Persons who, with their well-developed muscles, should have been able to walk miles, were tired out by a short walk; they took no interest in games, but preferred to lie dozing in the hammock in the woods. Sexually they were weak and irritable, easily excited sexually without being able to perform coitus normally, as faulty erection or premature ejaculation prevented their fulfilling the act. This condition was accompanied by extreme mental depression, a feeling of complete hopelessness, so that suicidal thoughts would often be complained of. Sometimes they would be bothered with such continual sexual excitement that masturbation would be suppressed only by exercising most extreme effort of will-power.

In another group of patients the psychic sphere was less influenced, but peripheric symptoms made themselves more prominent; especially were neuralgiæ, preferably of the intercostal nerves, observed; the heart's action was increased and irregular, dyspeptic symptoms, paræsthesiæ, numbness, heat and cold of various limbs and increased sweating on the side corresponding to the varicocele. Finally, in some cases, symptoms of an epileptiform nature, as petit mal, were complained of, as well as vertigo and spasmodic insecurity of gait in going along the street. This group of symptoms was seen more frequently on the left side of the body, hence the influence of the varicocele was undeniable. The writer has obtained excellent results

in these symptom-groups from hydro- and electro-therapeutics. A globular, button-shaped electrode is used, the anode being held above the inguinal ring by the patient himself while galvano-faradic massage is performed by the operator with the opposite pole in his hand, about one hundred strokes forming a sitting. The galvanic current is used at 1 m.a., the faradic until it is distinctly felt. Then a convex and bent electrode, of the length of one's finger, attached to the negative pole, is applied along the spermatic cord, the anode remaining at the original place, and a galvano-faradic current of the same strength is allowed to pass through; after a full minute the faradic current is switched off and the galvanic current turned on and permitted to flow through for a minute, when it is turned off. Cold water is employed in the form of half and sitz-baths, the radiating douche is applied along the spermatic cord, the perinæum and scrotum. During the day a well-fitting suspensory is worn to prevent the further development of the varicocele. With this treatment the writer has been able to turn melancholic neurasthenic patients into fresh-colored and healthy persons, who were capable of work and mental exertion. Yet one should not entertain too great hopes of this method of treatment. The writer has observed an analogous condition in women, proceeding from the ovaries. The treatment is very similar.—*Medicinische Neuigkeiten*, No. 39, 1891.

MASKED FORMS OF URÆMIA.—Dr. Guyot communicated several cases to the Medical Society of the Hospitals of Paris, where the uræmia was masked by a hemiplegia, accompanied by convulsive crises, which condition terminated in recovery. These cases are more frequent than is generally supposed. The previous presence of a facial neuralgia is often of great aid in making a diagnosis. It may be well to remember that very serious uræmic phenomena, either convulsions or coma, may set in without the usual prodromata, and when the urine contains but a small quantity of albumin. The writer treats such cases very successfully by venesection. The albuminuria, of course, must be paid attention to simultaneously. He has never observed such states in patients suffering from Bright's disease with large quantities of albumin in the urine.—*Le Bulletin Médical*, No. 101, 1891.

CASE OF ACUTE POISONING BY THE CHLORIDE OF BARIUM.—Dr. Ogier and Socquet, of Paris, report the case of a factory hand, who, having had the sulphate of magnesia prescribed as a purgative, instead of going to an apothecary took about 30 grams, $7\frac{1}{2}$ drachms, in a cup of water, of a white powder from a bottle standing in the factory, with an indistinct label upon which was written magnesia sulphate. He was immediately seized with violent vomiting and then diarrhœa. The vomited matter was first greenish and then bloody. Notwithstanding all treatment, the patient died in a few hours. The necropsy revealed the lungs slightly congested; the blood contained in the chambers of the heart was dark and grumous. In the stomach about 75 cubic centimetres of a brownish fluid were found; the mucous membrane of the stomach was swollen and dotted with ecchymoses. The kidneys were congested; the brain and its meninges were but slightly congested. As an antidote one may administer the sulphate of barium, to convert the soluble chloride into the insoluble sulphate; stimulate, as this poison especially depresses the heart's action.—*Lo. Sperimentale*, No. 10, 1891.

A CAUSE FOR LARYNGISMUS IN YOUNG CHILDREN.—Alfred Mantle found, in a desperate case of laryngismus, the cause of it a thickening and elongation of the uvula, with congestion and thickening of the faucial arches. The attacks ceased after ablation of the uvula.—*Brit. Med. Jour.*

PYÆMIC CONDITIONS FOLLOWING PNEUMONIA.—Dr. Boehr has observed three cases of pyæmia to follow pneumonia, of which two ended fatally. The symptoms consisted in purulent inflammations of the various serous cavities, as the pleura and joints, which partially opened outwards. In one case there developed several days before death clonic spasm, which pointed to a cerebral abscess. In the case which recovered there appeared on the twelfth day a parötis on one side during convalescence. The opposite gland was affected, so that both had to be opened — *Norsk Magazin for Sægenidenskaben*, No. 6, 1891.

CONTAGIOUSNESS LATE IN SYPHILIS.—Mauriac describes a case of syphilis in which a husband infected his wife four years and nine months after acquiring his chancre, in spite of having pursued a thorough course of treatment. The husband acquired his disease in July, 1885, and manifested but slight symptoms of the disease. He underwent a three years' course of treatment, during which time he had

but slight recurrences of the lesions, consisting of small, herpetic eruptions upon the scrotum. In May, 1890, his wife, with whom he had not had sexual intercourse for four years and four months, came under treatment for a syphilis that was from six to seven weeks old. Social circumstances almost certainly excluded any other source of infection than her husband. The discussion was participated in by Hardy, Fournier, Lailler and Mauriac. The latter mentioned two cases in which infection occurred after the lapse of five years and nine years, respectively, after the acquisition of the disease (both having undergone thorough treatment); the wife being the one infected in each case. In a third case infection of the wife occurred after three years' treatment. Fournier mentioned the fact of the appearance of so-called secondary symptoms in patients who have undergone treatment, as late as fifteen years after the chancre.—*Archiv. für Dermatol. und Syphilis*, Heft 5, 1891.

STROPHULUS INFANTUM.—Dr. Ernst Gebert, of Berlin, finds, next to chronic eczema, the most frequent disease of early childhood to be strophulus. The affection is characterized by the appearance of papules or blotches, of the size of a lentil, bright red in appearance and itching violently. In the middle they are provided with one or more vesicles and present an appearance similar to that of urticaria. They generally appear in the evening, after the children have gone to bed, and itch so much as to prevent sleep or to cause the children to scratch during sleep. During the day and in the cold the pruritus usually disappears, yet in severe cases it may even persist then. In place of the papules nodules remain which also give rise to severe itching for a longer or shorter time. The disease itself is benign, in most cases does not begin before the third month and usually does not last beyond the second or third year. There is no fever; the general condition is good, yet disturbances of digestion, generally slight, may intervene. Most of the children affected have an anæmic appearance. Hereditary syphilis seems to be a predisposing cause in some cases. It must be differentiated from:

Scabies, erythema exudativum, papular eczema, varicella, urticaria and pemphigus.

It is recognized by the characteristic papules, the statements of the parents on the course of the disease and the nocturnal itching.

Scabies may be detected by the burrows of the itch-mites; the palms and soles are rarely unattacked and also in children scabies generally causes pustules. Strophulus usually attacks the trunk and rarely the extremities. Further, strophulus runs a longer course.

Erythema exudativum is a rare disease in children; it begins with febrile symptoms, attacks symmetrically the extremities while strophulus is rarely symmetric.

Papular eczema presents smaller single papules which are crowded nearer together and nearly always connected with a hair-follicle; the surrounding redness is confluent, while in strophulus the single efflorescences are larger, scattered far apart and independent of the hair-follicles. In eczema one finds vesicles and pustules as well as crusts, which are absent in strophulus.

Varicella runs an acute course and appears but once.

In *pemphigus* the vesicles are situated upon the normal, slightly reddened and uninfiltated skin; the pigmentations which persist has chiefly an annular form, while in strophulus papules precede the vesicles and pigmentation, if present, assumes irregular forms.

In *true urticaria* the single papules are larger and sharply contrasted with the surrounding skin. The development and course of urticaria is entirely different from that of strophulus.

In *urticaria pigmentosa* the resulting pigmentation occupies the entire space of the preceding papule, while in strophulus the nodule remaining takes place of the centre of the papule, respectively of the vesicle which preceded.

In the treatment, the general condition of the system should be built up, all irritation of the skin should be removed. The children should sleep cool; local application of vinegar and water should be made before putting them to bed. In cases complicated with eczema he recommends tar-soap, following with cold effusions or a 3 to 5 per cent. naphthol and zinc salve. In incipient cases the use of the warm bath should be entirely stopped. A change to the country, good nourishment and care have also a great influence. The internal treatment given is naturally allopathic (antipyrin for the itching and iron for the anæmia).—*Wiener Med. Press*, No. 40, 1891.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

OPERATIVE TREATMENT OF VARO-EQUINUS.—A. M. Phelps (New York), after reviewing his first four cases, operated in 1879, three of which resulted in permanent cures, describes his operation, the open incision for talipes varo-equinus, as he at present performs it, and gives what he considers the proper operative methods, and their order, by which such cases should be treated.

1. *Phelps' Operation*.—An incision is made, beginning in front of the internal malleolus, extending one-third the distance across the sole of the foot, and down to the inner side of the neck of the astragalus. The following structures are successively divided, the artery and nerve being carefully avoided: the abductor pollicis, tibialis posticus tendon, the plantar fascia, flexor brevis muscle, long flexor tendons of the toe, and if necessary, all the branches of the deltoid ligament. The deep ligaments are then forcibly ruptured and the foot easily brought into a supercorrected position. In from eighty to ninety per cent. this operation will be sufficient. Relapses usually occur during the first year, and in about seven per cent. of the author's cases.

2. *Order of Operative Methods to be Employed in the Correction of Club-Foot*.—Manipulation and fixed dressings should first be faithfully tried, but when an operation becomes necessary, the foot *must* be supercorrected before it is completed; relapse is sure to follow when a little operation is done with the hope that the rest can be subsequently accomplished by machinery.

(a). *Tenotomy*.—The parts should be divided which first offer resistance, in the order in which they contracted when the deformity was produced, beginning with the tendo Achillis. This should be the first step, because, in one case in ten, the ligament extending from the tibia to the os calcis is shortened, and must be ruptured, as the vessels and nerves lie close to it. If an incision is first made in the foot, it is so weakened that it cannot be used as a lever to rupture this ligament.

(b). *Open Incision*.—If the skin be now found short, Phelps' operation is done, and great force is used after cutting each tissue.

(c). *Linear Osteotomy*.—If the above fail to easily supercorrect the deformity, the neck of the astragalus is divided with the chisel.

(d). *Removal of a V-shaped Piece*.—If osteotomy is not sufficient, a wedge is then removed from the body of the os calcis, the point of the V meeting the linear osteotomy of the astragalus.

(e). *Tarsectomy*.—In a few cases it will be necessary to excise the cuboid and scaphoid bones, and, as a last resort, recourse may be had to

(f). Pirogoff's amputation.

Bone operations will be necessary in ten or twelve per cent., and, in half of these, linear osteotomy is all sufficient. The mortality from osteotomy and tarsectomy is from three to five per cent.; these operations should never be the primary ones, and should never be performed until the soft parts have been lengthened. The foot is shortened in proportion to the amount of bone removed, and, when the astragalus is removed, the whole limb is shortened. Open incision has no mortality.—*University Medical Magazine*.

OPERATIVE TREATMENT OF IRREDUCIBLE DISLOCATIONS OF THE THUMB AND GREAT TOE.—Jordan Lloyd reports two instructive cases:

1. *Dislocation of Great Toe Backward*.—Patient was seen the day after the injury, previous attempts at reduction having failed. These were repeated with like result and operation at once performed. The great toe was completely dislocated on to the back of the metatarsal bone, the head of which projected prominently in the sole of the foot. A vertical two-inch incision was made with its centre over the head of the metatarsal bone, which was found to have thrust itself between the heads of the flexor pollicis muscle. The anterior ligament with its imbedded sesamoid bones was torn away from the metatarsal bone and had slipped behind the head of the latter, constituting the chief obstacle to reduction. Before this could be accomplished the anterior metacarpo-phalangeal ligament had to be divided by a vertical incision in its middle line. The deformity was then easily reduced, but as easily recurred until the divided ligament was sutured. Healing was rapid and the result satisfactory.

2. *Backward Dislocation of Thumb*, in a seven-year old girl, of four months standing. An incision was made in the line of the thumb over the head of the metacarpal bone and the articular surface exposed. The phalanx lay completely behind the metacarpal where it had drawn the anterior metacarpo-phalangeal ligament which had been torn from the latter bone. The heads of the flexor brevis pollicis had been forcibly separated and lay posteriorly to the metacarpal bone. The anterior ligament was divided vertically, the internal head of the flexor nicked, and reduction easily accomplished, displacement being prevented by suture of the ligament and muscle. The wound healed kindly, and the resulting function was nearly normal.

These cases show that the obstacle to reduction is not only the generally taught one, viz.: the head of the metacarpal bone being caught between the two heads of the flexor brevis muscle, but also and especially, the anterior metacarpo-phalangeal ligament with the sesamoid bones which slip behind the metacarpal head. The tendon of the long flexor which is occasionally found between the ends of the displaced bones, was not here an obstacle, as it lay to one side in the first case and was not seen in the second. Although resection of the metacarpal head has been resorted to successfully in such cases and now presents but few dangers, reduction can be accomplished without it in the manner described and recurrence can be prevented by suture of the ligament and muscle.—*London Lancet*.

WHAT CAN WE EXPECT FROM THE SURGICAL TREATMENT OF EPILEPSY?—B. Sachs (New York) presents a very logical review of this question in a paper read before the New York Academy of Medicine. The author starts out with the proposition, which is doubtless sound teaching, that epilepsy is but a symptom, not a disease *per se*. In support of this proposition he makes the statement that as time goes on we see relatively fewer cases of idiopathic epilepsy. Even cases of the latter kind he does not regard as functional diseases, for as our methods of investigation improve, we will doubtless be able to detect their anatomical sub-strata. At the present day many cases reveal post-mortem an excess of neuroglia tissue, with the formation of small fibrils emanating from the spider cells of the neuroglia.

The author believes firmly in the association of a secondary sclerosis of the cortex with epilepsy, and on this proposition the question of operative treatment of epilepsy depends. In idiopathic epilepsy we cannot expect results from operation. In Jacksonian epilepsy, where a focal lesion is present, and there is also secondary sclerosis, we may operate. In early childhood the cortex often suffers focal lesions which may well be called traumatic, if they were due to an external force. We have a meningeal hæmorrhage, the clot resting upon the cortex of the brain may be absorbed, but it gives rise by degrees to local changes which finally lead to secondary changes in the form of a lobar sclerosis. Paralysis and epilepsy are the chief symptoms of this condition.

We are all familiar with the fact that the convulsive seizure of a localized type is due to an irritative lesion of the motor or sensory centres. Those parts are capable of discharging a convulsion that are not destroyed. These injuries and morbid processes rarely lead to the destruction of a centre; it is capable of discharging, and the irritation it needs seems to be supplied by that secondary sclerosis of which the focal injury is a prime cause. A secondary sclerosis being the cause of the discharging lesion, what should be our course? We must either prevent the formation of this secondary sclerosis or neutralize its effects when it has developed. The first of these can only be accomplished by diminishing the initial lesion, and if possible to remove it. This is a plea for early operation in traumatic and organic cases. The second indication is fulfilled by excising the centre.

We cannot expect good results from late operation if the sclerosis exists in other parts than the one excised. Excision of a centre means paralysis of the part; but most patients will prefer a localized palsy to epilepsy. The writer accounts for the late development of epilepsy after injuries and disease by the fact that it takes a long time for this sclerosis to be set up, and this sclerosis is the essential lesion in these cases. He presents the following conclusions concerning the surgical treatment of epilepsy:

1. In a given case of traumatic or of organic lesion, operate as early as possible, so as to prevent the development of secondary sclerosis.
2. If you have not operated at the outset, the onset of epilepsy is a warning that secondary sclerosis has been set up; by operation at this time you may avoid an increase of the trouble.
3. Excision of the diseased area is the only rational operation; if all other centres are not in an irritable condition, the operation may be thoroughly successful.

Traumatic cases call for immediate surgical treatment. Whenever the skull has sustained a severe or even a moderate injury an exploratory incision should be made to insure that there is no depression of bone. If in doubt as to the proper course then to pursue, give the trephining the benefit of the doubt.

When epilepsy has developed there is still hope that it may be cured by surgical methods. Whenever depressed bone presses upon any part of the cortex, or an old scar acts as a cause of irritation, the removal of such bone or scar is clearly indicated.

Reasons for the failure to cure in many cases are found: 1. After excising one irritable area, e.g., the arm, the neighboring face or leg centre may after a lapse of years, take on a sufficient degree of irritability to become a discharging centre. 2. The operation itself may lead to the formation of cicatricial tissue, and thus do more harm than good.

The epilepsies accompanying cerebral palsies of children constitute a large class. The pathological changes in this condition are hæmorrhage or thrombosis. Cases of this character are the only non-traumatic ones calling for surgical interference. The author believes in an early trephining. Whether any further operative procedure than this should be undertaken will depend upon the result of the exploration. Even a simple trephining often does good. Early treatment is absolutely necessary, for 44 per cent. of these cases develop epilepsy subsequently. In conclusion the author says, "the surgeon may be able to cure a few cases of epilepsy. He will be able to improve many, but surgeons and neurologists should in future make an earnest effort to prevent epilepsy."—*New York Medical Journal*.

TREATMENT OF ACUTE GONORRHOEA.—C. E. Cotes (London), under the title "A New Treatment of Acute Gonorrhœa," revives the use of strong nitrate of silver applications, the only difference being that they are made with more exactitude and to the diseased area alone. Forty-two cases were treated, of which but two were fresh (of two days standing). In the former, several of which had already developed severe chordee, the cure was complete on an average in less than twelve days; the latter were well in five days. Cured cases were examined with the endoscope and a normal urethra invariably found. The patient was first made to micturate to clean out the canal and placed on his back. With the endoscope and the electric light the limit of the disease was accurately made out; this usually extended for five inches, and as much as four inches even by the third day. The surface being carefully wiped with cotton, is mopped with a solution of nitrate of silver (ten grains to the ounce). Pain from the use of the endoscope can be overcome by cocaine. Burning usually follows the application, but this soon passes off. The patient takes a bath, remains in bed for twenty-four hours, cleans out the bowels and takes an alkaline mixture. The subsequent treatment consists of injections of Condy's fluid (a drachm to the pint). The immediate effect of silver nitrate is to produce a free purulent discharge for one or two days; this rapidly diminishes, however, becomes thin and watery, and soon ceases. Dysurea and even chordee are similarly affected. The endoscope shows after urination and even injection a thick discharge clinging to the walls, proving the difficulty of getting any injections to act on the diseased mucous membrane. Such applications do away with the danger of over-zealous injections by carrying infectious material backward.

C. Slater (London) has followed this treatment with bacteriological examinations. During the first twenty-four hours after the application the discharge is chiefly purulent, but the relative number of pus and epithelial cells rapidly changes, until the former almost entirely disappear at the end of two days. There is also an increase in fibrinous exudate in which the cells are entangled. Gonococci may disappear entirely in two days, and do not persist after seven days. In twenty-four hours they are very considerably diminished and are met with in the exudate or attached to the epithelial cells, but not in their usual situation in the pus cells. Nitrate of silver apparently has a powerful effect in eliminating these micro-organisms.—*London Lancet*.

INTRAVENOUS INJECTION OF SALT SOLUTION FOR HÆMORRHAGE.—Pye-Smith (Sheffield) reports a case of bullet-wound of the leg with collapse from hæmorrhage. Before amputation, twenty-four ounces of saline solution (three-quarters per cent.) were injected into the saphenous vein. The symptoms recurring at the close of the operation, a similar quantity was again injected with good effect. The patient rallied well, and made a good recovery. Such injections are safer, and more easily carried out, than transfusion of blood.—*Medical Press*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

SYMPHYSEOTOMY.—Dr. Spinelli, one of the most distinguished pupils of Prof. Morisani, is now in Paris for the purpose of bringing under the notice of the French obstetricians Dr. Morisani's efforts to introduce into the practice the operation of symphyseotomy, which permits the fœtus to be brought into the world alive without having recourse to the Cæsarian operation. The obstetricians of the whole world have remained up to the present indifferent to the results of the Neapolitan school. Prof. Morisani has therefore decided to place the matter before the International Congress, to be held in Rome in 1893, and in the meanwhile to call the attention of specialists to it in order that they may be prepared to discuss it in due time. For this reason, Dr. Spinelli has gone to Paris. Some of the specialists were skeptical, others indifferent, but the most distinguished of them all, Prof. Pinard, listened with attention to the young surgeon, and proposed that he should give an address in the Buadelocque Hospital, to be followed by an experimental operation. On the 16th ult., Dr. Spinelli gave satisfactory replies to all the objections raised by Profs. Pinard, Tarnier and others. In the operation Spinelli's statements were fully realized.—*Medical Press and Circular*, December 2, 1891.

REPORT ON TWENTY-FOUR CASES OF SYMPHYSEOTOMY.—Under the title, "The Results of Antiseptic Symphyseotomy at the Obstetrical School at Naples," under Dr. Morisani, Dr. Spinelli gives some interesting cases with the following results. In twenty-four cases of symphyseotomy the operation was entirely successful for twenty-four mothers and twenty-three children. The infant which was lost was extracted by version, markedly asphyxiated, and although resuscitated, succumbed twelve hours later.

These results seem to confirm the following observations:

1. An infant at term, and well developed, can be delivered by means of symphyseotomy, in cases of malformation of the pelvis, where the conjugata vera is, at least, sixty-five millim., *i.e.*, in cases where all accoucheurs have heretofore advised embryotomy or Cæsarean section.

2. A woman can submit with impunity to this operation, if antiseptic precautions are observed.

Dr. Spinelli also considers that, in view of the favorable results obtained by Dr. Morisani, the operation, which had fallen into disfavor, should be looked into more carefully by conscientious obstetricians.—*Annales de Gynécologie et d'Obstétrique*, January, 1892.

AXIS TRACTION FORCEPS.—Hagel prefers the Simpson model of the axis traction forceps, as it is light and neatly made and fulfils all the claims of the Tarnier forceps. It has no especial advantage in a low head presentation, except in rare cases when the sagittal suture reaches the outlet in the straight diameter. In the high operation the danger lies in the great power of compression which this forceps is capable of exerting on the fœtal head, and of nineteen reported cases two children were born dead, and of the others nine were more or less injured, three so badly that they died soon after birth. When the occipito frontal diameter lies obliquely, especially in a flattened pelvis, one of the blades must pass over an eye, or, when the occiput lies low in a generally contracted pelvis, the forceps will press on the frontal bone on one side and on the temporal on the other, and a deep mark or fracture is very likely to occur on the side toward the promontory; the more easily this will be averted the nearer the sagittal suture is in the straight diameter. The advantage of the axis traction is very apparent when the necessity for interference occurs on account of the mother, when turning is not practicable, and the question of perforation arises.—*Centralblatt für Gynäkologie*, No. 41.

WEAK PAINS IN OLD PRIMIPARÆ.—Dr. Borner, after careful observation and investigation, comes to the conclusion that this condition can assume the gravest proportions. It may be primary or absolute, in which case it is generally due to the gradual retrogression in the innervation and nutrition of the uterus through its long-continued inactivity, or through the functional disturbances of the genital apparatus arising from the approaching climateric. The condition can influence

the prognosis of birth very unfavorably, and the author thinks that too limited a space is given to the subject in the text-books, while so much is devoted to malformation, etc., of the uterus. Characteristic of this particular form of inertia is its continuance throughout the whole of labor, noticeable also in the lack of effect of these pains, which can be recognized from the beginning of the first stage. As a result of this condition there can occur delay in the birth, exhaustion of the mother, danger to the fœtus, enforced operative interference, and difficulties after delivery. Borner recommends perforation in those cases where the application of forceps is counterindicated by the delay in canalization, or where deep incision is not considered best. In these cases the question of Cæsarean section should be carefully weighed.—*Centralblatt für Gynäkologie*, No. 41.

SCARLET FEVER IN THE PUERPERAL PERIOD.—From an interesting epidemic of scarlet fever at the Lying-in Hospital at Liège, the following points are deduced:

1. Scarlet rash appears to be less epidemic and severe in puerperal cases than asserted by many, especially if active antiseptic methods are adopted.

2. It is contagious at least two months after its disappearance, and by means of the epidermic scales.

3. The infection can take place through the epithelium of any denuded spot, especially if there is any excoriation of the nipples.

4. It can develop locally (lymphangitis of the mammæ), or in a general septic infection.

5. Antiseptic precautions are especially necessary to prevent septicæmia with the mammæ, as a starting-point.—*Graef Halle. Centralblatt für Gynäkologie*, No. 48.

THE DIAGNOSIS OF CANCER OF THE UTERUS.—Leopold.—1. Carcinoma uteri has always an epithelial origin. 2. It is an atypical epithelial neoplasm. 3. Its most frequent seat is below the level of the os internum, and it originates in the epithelium of the portio, seldom in that lining the cervical canal. 4. Commencing epithelioma of the portio vaginalis is more frequent than has been supposed, and even when apparently springing from the cervical canal its connection with the squamous epithelium of the portio can be demonstrated. 5. In 25 per cent. of the cases of carcinoma of the infra-vaginal cervix the disease extends to the os internum. 6. In case of carcinoma of the portio the corporeal endometrium is usually hypertrophied. The writer has never observed accompanying sarcomatous degeneration of the endometrium, and rarely adenoma. 7. Isolated cancerous nodules may exist in the corpus uteri in connection with cancer of the cervix. 8. Primary carcinoma of the body of the uterus nearly always assumes the diffuse superficial, seldom the isolated nodular form. The first stage is thickening of the mucosa, followed by glandular proliferation, and finally invasion and destruction of the muscular layers. 9. The epithelial growth is composed of papillary projections richly supplied with bloodvessels, so that it may be properly described as carcinoma papillare. 10. The term "malignant adenoma" is misleading, since an adenoma is a benignant neoplasm. 11. In the initial stage of the disease the diagnosis may be positively established by the removal of fragments with the curette. When extensive ulceration has occurred the microscopical diagnosis is uncertain, since only necrosed tissue is removed by the curette.—*Archives of Gynecology*, January, 1892.

CASE OF PARALYSIS AFTER SUBCUTANEOUS ETHER INJECTION.—Two cases are reported, one by Dr. Feaux as follows: Patient collapsed after the manipulations necessary to empty the uterus after abortion. Two ether injections were given in the upper third of the left fore arm upon the dorsal side. The next day the patient had a feeling of numbness in the left hand, and upon investigation it was found that middle, ring and little fingers were paralyzed. The galvanic current was given and in four weeks the patient was well, though after a year a weakness was still felt in that hand that it became easily tired.—*Centralblatt für Gynäkologie*, No. 46.

MEDICAL GYNÆCOLOGY.—A patient recently under observation had been under gynæcological treatment for the past five years. She passed the menopause four years before. She suffered from more or less constant pain from her right iliac region to her right shoulder. The ascending and transverse colon were greatly packed with feces. Examination of the pelvis was entirely negative beyond an abundant leucorrhœa. The unloading of the colon was immediately followed by

relief of the symptoms. The best means to relieve a loaded bowel are colonic flushings administered with the patient in the genu-pectoral position. The patient placed thus can be made to receive anywhere from two to six pints of water. The water should be used as hot as can be borne, otherwise it may produce violent tornuria. After the colon has been filled the bowels should be thoroughly kneaded until by pressure the loculi are distended, when their contents will drop out into the volume of water. As a rule it is safe to advise daily colonic flushings until no more dark-colored fæces come away. The worst looking and most offensive discharges sometimes come the twelfth or fifteenth day of the daily flushings. Two symptoms without abdominal examination are always suggestive of possible colonic impaction, and where present they always lead to an examination; they are the presence of chloasmic spots and the voiding habitually of very dark or black fæces.

A form of renal disorder about which much has been written in the past five or six years is renal insufficiency. The average human adult passes anywhere from five to eleven hundred grains of urinary solids every twenty-four hours. Patients who pass habitually a greatly diminished amount of urinary solids daily are persons who are suffering from veritable uræmic poisoning. It is simply astonishing to see how common renal insufficiency is in most gynecological cases. When patients are passing only about 400 grains of urinary solids a day, we will find them presenting various degrees of nervous irritability. When the amount is lessened, say to about 300 grains per day, we find this nervous irritability manifested in various urgent ways. When the solids are diminished still further, say 200 grains per day, we find the invasion of the nervous system so grave as to demand our most solicitous attention. The simplest formula for calculating the amount of solids passed daily is to multiply the last two figures of the specific gravity of the voided urine by the number of ounces of urine passed in twenty-four hours, and that product by $1\frac{1}{16}$. We can thus calculate the number of grains of urinary solids passed in twenty-four hours.—H. Etheridge, M.D., *American Journal of Medical Sciences*, January, 1892.

CASTRATION FOR EPILEPSY.—Dr. Howitz, of Copenhagen, reports four cases. In two cases there was an hereditary tendency, and in two the attacks began in childhood, while in the other two about the time of menstruation. In two cases the attacks increased during pregnancy; in one case during each menstruation, and, in the fourth, after nearly four years' interval, returned during lactation. In all four cases, the ovaries were cystic and the adnexa more or less diseased.

Amenorrhœa followed in all four cases, although there was one in which, for six or seven months, a slight hæmorrhage appeared.

In only one case was there a cure; in one, an amelioration, and in two no improvement. It is worthy of notice that the case of cure was in the one which presented the most unfavorable array of symptoms. These observations were made from two and one-half to four years after the operation.—*Centralblatt für Gynäkologie*, No. 43.

THE TREATMENT OF HABITUAL ABORTION.—Apropos of the good results obtained in severe cases of hysteria from repeated subcutaneous injections of chinin. bimuret, it is asserted that it is a striking remedy in habitual abortion. In a case reported by Dr. Fresnay, he gave for the first three months, ten days before the time of the former appearance of the menses, two subcutaneous injections, ordered rest in bed, and gave three times a week, subcutaneously, ferrum solubile.—*Centralblatt für Gynäkologie*, No. 48.

VAGINAL HYSTERECTOMY FOR UTERINE CANCER.—A very important point in diagnosis is, if hæmorrhage occur on careful examination, in all probability it is malignant, rarely mere granular degeneration. The prognosis after operation is better for patients of advanced years than for young subjects. Dr. Bantock advises the use of the ligature on either side of the uterus and division between the uterus and ligaments; also to avoid the vaginal mucous membrane in closing the opening.—*British Gynecological Journal*.

DRAINAGE IN LAPAROTOMY.—Mr. Tait keeps his patients in bed forty-eight hours before operation. He purges them freely and withholds fluids after the section, and purges early after operation. He relies upon these more than upon drainage, but he still drains when clearly indicated.—*Annals of Gynecology and Pædiatry*, January, 1892.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY,

CONDUCTED BY
CHAS. M. THOMAS, M.D.

HYGIENE OF THE EYES.—Dr. H. H. Crippen, of New York, in the *Medical Argus* for December, 1891, writes of the principal points of visual hygiene and of the evil resulting to the eyes from the now prevalent forcing system of education. In the school room the vital points for consideration are the proper distance for using the eyes, a satisfactory illumination and the necessity for properly printed books. The great thing to avoid is reading or writing at a distance less than 12 inches. The child should have the least possible temptation to assume attitudes in too close proximity to near work, for if this is prevented those congestions to the head which are of such importance in the development of near-sightedness where there is a predisposition to that condition will be avoided.

Books for the school room should be printed in well marked type on a clear white paper, or, according to a French Commission of 1881, a paper of a slightly yellowish tint.

It is necessary that the school room be supplied by natural, not by artificial light, which must never shine directly in the eyes. In unilateral illumination light from the right is preferred, so as to avoid the shadow of the right hand upon the paper in writing. The best artificial light is the incandescent electric light (such as the Edison or Swan system). If properly placed and surrounded by proper precautions it has very few disadvantages. No matter what the advantages or disadvantages of any artificial light may be, it cannot be other than a source of danger to the eyes unless properly placed. The light must not be too far above the head. It should be so surrounded by a shade as to protect the eyes from the direct rays, and at the same time throw all the light upon the work. In a word, the eyes must be protected from too great or too little light, from heat and from all direct rays of artificial light.

BROMOFORM AS A TOPICAL APPLICATION.—Dr. S. Solis Cohen has recently employed bromoform in a severe case of ozæna as a topical application to the nasal mucous membrane after thorough cleansing with hydrogen dioxide. The absence of the severe local reaction anticipated, together with the extraordinary success of the measure, not only in destroying the odor, but in controlling morbid secretion, encouraged him to use the same agent as a topical application to tuberculous and other ulcers of the larynx, after cleansing with hydrogen di-oxide. Here the agent seemed to exert analgesic, as well as disinfectant properties, as pain was relieved and healing apparently promoted. The agent being extremely volatile the immediate effect is transient, and he has, therefore, followed this application with insufflations of iodoform powder.—*Occidental Medical Times*.

PATHOLOGICAL CONDITIONS OF THE PUPIL.—Dr. Harold Phillipsen, of Copenhagen, Denmark, has made a careful and exhaustive study of this subject. In diseases of the cerebrum the pupillary symptoms may appear either as general cerebral symptoms together with headache, vertigo, choked disc, or as symptoms of disease of certain parts of the cerebrum, topically localized symptoms. The former are usually bilateral while the latter are generally unilateral. These are thought to be due to changes in the intracranial circulation. All brain-diseases with an acute course and rapidly occurring changes in the intracranial pressure must necessarily be accompanied by pupillary symptoms. Here belong hæmorrhage, either traumatic or spontaneous, hyperæmia of the cerebral meninges, inflammations, with the formation of exudates or accompanied by œdema, while diseases of the brain with slowly increased pressure need not be associated with pupillary phenomena. The symptoms are bilateral in such cases. In subdural hæmorrhages one not rarely finds unilateral pupillary symptoms, and when the patient is observed early, before changes in the intracranial pressure have had opportunity to develop, it may be regarded as a focal symptom indicating on which side the hæmorrhage has occurred. In pure concussion of the brain, there should be no changes in the pupil; if such exist they denote a complication, probably subdural hæmorrhage. Simple congestion of the meninges may produce pronounced pupillary phenomena, for example, in sun-stroke, we find, as a rule, contracted pupils. Contracted pupils and injected conjunctiva are the premonitory signs, according to Förster of con-

vulsions in children from cerebral hyperæmia. Pupillary symptoms are also found in inflammatory conditions of the brain's membranes. Griesinger emphasizes the contracted pupil as characteristic of the apoplectiform attack of hæmorrhagic pachymeningitis. The narrow pupils of meningitis, both tuberculous and non-tuberculous and especially basal meningitis are due no doubt to the local action of the exudate upon motor oculi nerve at the place of exit. Hence one finds the pupils of unequal size. Not often one finds more or less rhythmic and regular changes in the size of the pupils—hippus. When they are thus contracted the cutaneous reflex is usually absent as the patient is more or less unconscious. In the last stage when the symptoms of depression predominate the pupils are large and without reaction. If now one evacuate some of the cerebro-spinal fluid by puncture, the pupils diminish in size and react to light. In intracranial hæmorrhages, the condition of the pupil varies, according to the extent and violence of the effusion. Some writers would differentiate cerebral embolism from cerebral hæmorrhage by the presence of normal pupils in the former condition. The writer formulates the following: greater hæmorrhages and embolism of great extent may be accompanied by pupillary phenomena, while lesser hæmorrhages and embolism of less extent may be unassociated with pupillary symptoms. Hæmorrhages or embolism of the pons may also produce pupillary symptoms. The contraction may be both unilateral or bilateral. Yet one must still remember that a similar picture, coma, with contracted pupils, may be due to opium poisoning. Affections of the most anterior portions of the pons are especially liable to be accompanied by pupillary phenomena, probably as a consequence of direct irritation of the nucleus of the sphincter iridis in the floor of the third ventricle. Cheynes-Stokes breathing, which is so frequently a symptom of so many brain diseases, presents contracted pupils with loss of reaction to light during the pauses. Contracted pupils usher in hysteric and epileptic attacks, while during the convulsion the pupil is dilated and without reaction. The same holds true of the attack of cortical epilepsy. In progressive paresis the pupillary symptoms are fœcal of a varying origin. They may be due to disease of the ependyma of the floor of the third ventricle, with paralysis of the sphincter (iridis), insufficient reaction to light and inability to converge. These are most frequently the first symptoms noticed. Most often one finds a one-sided dilatation, which may persist a long time to disappear or jump over to the other eye (jumping mydriasis.) This may also be due to syphilis and no brain disease necessarily follow; the writer has observed several such cases, through twelve to sixteen years. The reflex movements may still be normal even if dilatation be present, others may present loss of reflex. In mental diseases the condition of the pupil varies, but changes are frequent. Any mental disease may run its course without pupillary symptoms; they, on the contrary, may be present as unilateral or bilateral, may appear and disappear. According to Arndt nervous individuals have as a rule dilated pupils. The same is true of those mental diseases which run an acute course, as mania and melancholia, as long as they are not accompanied by sopor or depression. Contraction of the pupil in such cases is a premonitory symptom of a threatening parietic state. Spastic myosis is also a symptom of disseminated sclerosis of the brain and spinal cord. Persons who work at fine work, and strain their accommodation or use glasses have usually a very contracted pupil from increased accommodative tension, due to contraction of the sphincter muscle. Lesions of the third nerve, wounds of the cornea, foreign bodies in the eye, operations on the conjunctiva and inflammations of the iris cause a reflex spastic myosis. In poisoning by opium or chloral the pupil is contracted down to the size of a pin-head. Noël claims the pupil to be contracted in tobacco amblyopia and dilated in that of alcohol; the writer cannot support this. This condition, spastic myosis, may be present in any brain-disease. Paralytic myosis is generally due to disease of the cervical cord. It may be either single or double. It appears in chronic, inflammatory, degenerative diseases of the spinal cord, especially in tabes dorsalis. It is not constant, is combined, with loss of pupillary reflex (Argyll-Robertson's pupil), and may present some dilatation during the gastric crises and attacks of lancinating pains. Paralytic myosis may be an early symptom of tabes dorsalis, yet it is more frequently seen in a more advanced stage of the disease. Yet the disease may run on for years or even its entire course, without a pupillary symptom. Poliomyelitis anterior, myelitis cervicalis, transverse meningitis spinalis, tumors and hæmorrhages into the cervical cord, producing direct compression or secondary myelitis may also be accomplished by paralytic myosis. Bulbar paralysis generally does not present pupillary symptoms and when they do

they are due to a complication; poliomyelitis anterior or disseminated sclerosis. Diseases of the cervical sympathetic are accompanied by oculo-pupillary, vasomotor and trophic symptoms. The pupil is narrow, reacting to light, the eye-fissure narrowed and the eye sunken in the orbit. There is vascularization, perspiration, and later, atrophy of the corresponding side of the face. The causes are traumatism; severing or lesion of the cervical sympathetic by piercing or cutting instruments or injury during surgical operations. Gun-shot wounds, fracture of the clavicle, where the brachial plexus has been involved, tumors of various kinds, abscesses, swollen lymphatic glands, etc., may be the cause. Diseases of the upper portion of the thorax, especially mediastinal tumors, aneurysms, etc., are often accompanied by paralytic myosis. Under these latter must be reckoned those cases where paralysis of the sympathetic follows disease of the apices of the lung and its coverings, as in pleuritis, where branches of the sympathetic are found embedded in pleuritic exudate masses and glued to the apex.—*Hospitals-Tidende*, No. 40 and 41, 1891.

EXCISION OF THE MEMBRANA TYMPANI, ETC.—The operation of excision of the membrana tympani and of one or more ossicles is the last resort in the treatment of dry otitis, and is practiced when other treatment has failed to give any result. The operation is indicated:

1. Whenever an artificial perforation of the drum-head sensibly improves the hearing, *e.g.*, when the hearing distance for the watch is increased by the operation from 3 or 4 cm. before to 20 or 25 cm. after.

2. When the chain of ossicles and the tympanic membrane have lost their mobility in consequence of fibrous and calcareous degeneration and of synechiæ.

3. Patients who generally receive most benefit from the operation are those afflicted with paradoxical deafness and perceive the diapason-vertex better in the deeper ear.

4. In cases of mono-auricular deafness with tinnitus which tends to affect the psychological condition of the patient.

5. The operation is far from being urgent in those cases of one-sided deafness without other subjective symptoms.

6. It is contraindicated in all cases in which the subjective symptoms have a nervous origin either reflex or central.

Conclusions.—The removal of the membrana tympani and of the hammer is sufficient in all cases in which the membrana is very much thickened and where the movements of the chain of ossicles are free.

The result of the operation is in general very favorable as regards both deafness and tinnitus even in unlikely and long standing cases. The tinnitus is almost always diminished and disappears in the majority of cases; the author has, however, seen it increased in one case. The hearing improves noticeably, sometimes in a remarkable fashion. For the purpose of producing a moist condition of the mucous membrane, it is advisable to use, beginning some weeks after the operation and when all traces of hyperæmia have disappeared, the following instillation:

R. Iodine bisublimated,	0.01
Liquid vaseline,	80.

Four or five drops are to be used, at first every second day, and then every fourth or fifth day. The intervals may later be increased.—*Revue de Laryngologie, d'Otologie et de Rhinologie*, Nos. 15, 16, 17, 1891.

CAMPHOR-MENTHOL IN CATARRHAL DISEASES.—In the *Jour. Amer. Med. Assoc.*, October 24, 1891, Dr. Seth S. Bishop gives his very favorable experience with this compound, the liquid resulting from rubbing together equal parts of camphor and menthol and diluting with a mineral oil. It gave excellent results in relieving the swelling and irritability of acute nasal catarrhs, improving the character of the discharge, and by a few repetitions securing the relief of the stenosis and obviating the operative measures which had seemed unavoidable.

Its effect in laryngitis has appeared as happy, and its injection through the catheter into the Eustachian tube and tympanum has been attended by only good results. For the latter purpose a solution of 3 to 5 per cent. is as strong as is safe; most noses and larynges will bear 10 per cent., while in marked hypertrophic rhinitis, with copious discharge, even 25 per cent. is well borne. "Finally, camphor-menthol contracts the capillary blood-vessels of the mucous membrane, reduces swelling, relieves pain and fulness of the head or stenosis, arrests sneezing, checks excessive discharge, and corrects perverted secretion."

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., FRANK H. PRITCHARD, M.D.,

AND

E. MELLVILLE HOWARD, M.D.

TREATMENT OF ASTHMA.—Dr. P. Jousset, of Paris, France, divides the treatment of asthma into the treatment of the attack and the treatment of the disease.

Treatment of the Attack.—The principal remedies are: ipecac, sambucus nigra, cuprum, lobelia inflata and bryonia.

Ipecac.—In all schools this is the principal remedy for the treatment of the attack, where its action is perfectly homœopathic, for asthmatic attacks have been produced by breathing the powdered drug. It is indicated by considerable dyspnoea, accompanied by wheezing and the first signs of asphyxia; there is a peculiar cough, caused by a tickling in the large bronchi and accompanied by gagging and suffocation. He prefers the first decimal attenuation of the tincture, a teaspoonful every half hour.

Sambucus.—This remedy is also indicated in the attack by the predominance of the dyspnoea over the cough; the face is violet and the signs of asphyxia are more advanced than in the ipecac case. The wheezing which accompanies the dyspnoea is more marked. This drug is far from having the notoriety which ipecac has, and at the same time it cannot be called a trustworthy remedy. It should only be prescribed when ipecac fails. The mother tincture should be used 10 drops in 4 ounces of water, a teaspoonful every half hour.

Cuprum.—This remedy is indicated by a spasmodic dyspnoea, with a feeling of compression in the chest, which amounts almost to suffocation. The cough is suffocating; if vomiting relieves the patient this is also an indication for cuprum. The same holds good for cramps and muscular spasms which may appear in other parts of the body. The writer employs the sixth dilution most frequently, 2 drops in 4 ounces of water, and a teaspoonful every half hour.

Lobelia inflata.—The author has had but little clinical experience with this remedy. According to its toxicology its action may be compared with that of the Solanaceæ. The experiments of Barrallier, made with the mother tincture, show that in doses of 25 drops to 2 grams (30 drops), lobelia produces dyspnoea with contraction of the larynx and thorax, slowness of the pulse and irregularity of the heart's action. Dr. Richard Hughes regards stomach symptoms as a necessary accompaniment for its indication. The dose is the same as of sambucus.

Bryonia.—Bryonia is indicated where there is a certain degree of bronchitis present, and especially a pain in the side, which is increased by the respiratory movements. In this condition bryonia is an excellent remedy. It is given in the same dose as cuprum.

Aconite.—Dr. Richard Hughes advises the employment of this drug when the attack has been brought on by dry and cold air. The dose is the same as of sambucus.

Moschus.—Moschus is indicated when there is a very marked spasm of the muscles of the larynx and thorax, and is especially useful in children. The decimal trituration may be administered by olfaction or internally in doses of one and one-half grains per powder.

Inhalation of Various Substances.—Nitro paper and some others containing preparations of belladonna, stramonium or arsenic sometimes very rapidly relieve the most intense asthmatic attacks. The first of these is entirely inoffensive, and will not interfere with the action of the remedies administered.

Treatment of the Disease.—There are four remedies which deserve our attention in the treatment of habitual asthma. These are: nux vomica, arsenic, sulphur and the iodide of potassium.

Nux vomica.—Dr. Richard Hughes places *nux vomica* at the head of these remedies which are curative in asthma, and he adds that one of the first successes of Hahnemann was made by the prescription of this remedy, in massive doses, in a case of asthma. The dyspnoea produced by *nux vomica* resembles that of asthma. The respiration is slow, labored, and sighing with a sensation of constriction of the chest. This remedy would seem indicated, according to the writer's opinion, when the asthmatic attack is preceded by sneezing and fluent corvza. If hæmorrhoids be present the indication of the remedy is doubly certain. The writer employs the third trituration most frequently, one grain morning and evening.

Arsenic.—Arsenic is more often indicated when the disease is chronic with a habitual dyspnoea, associated with wheezing, irregular cough, expectoration of a liquid, viscid, transparent and frothy mucus during the intervals. The arsenical dyspnoea is a faithful image of an asthmatic attack—respiration is difficult, anxious and accompanied with wheezing and a sense of constriction of the chest and even apnoea. Anguish, cardiac anxiety and recurrence of the attacks at night complete the indications of this remedy. The lower triturations are those which should be employed. The resemblance which *nux vomica* and arsenic bear to each other in their indications led M. Roux to suggest that they be alternated. He prescribed *nux vomica* in the evening and arsenic in the morning, 10 to 20 centigrams (11½ grains), of the third trituration. This treatment has given the writer excellent results. It must be continued for months, giving the remedies for a period of twelve days, with intervals of four to eight days of rest, according to the condition of the patient.

Sulphur.—The principal, and yet not the only one, is the concomitance of a cutaneous affection, especially if the asthma aggravates with the diminution and retrogression of the skin disease. Dr. Chargé adds the following indications: Old age, concomitance of a catarrh; attack coming on during sleep, sensation as if the patient had swallowed dust; difficulty in breathing, even the slightest quantity of smoke. Try to find the most efficacious dilution.

Kali hydriodicum.—The iodide of potassium is recommended both by empiricism and its pathogenetic history. Bahr has called the attention of physicians to the frequency of asthma as a pathogenic manifestation of this remedy (*Deutsche Klinik*, 1856); he described three cases of iodic asthma, which were of extreme interest. The disease manifests itself after the prolonged use of the drug, while an acute poisoning by iodine never causes asthma (Richard Hughes, *Manual of Therapeutics*, p. 402). The relations, now better known, of arterio-sclerosis and emphysema explain the reason why iodine has been successively given in a certain number of cases of asthma. There are physicians who prescribe the iodide of potassium to all asthmatics, and increase the dose until they have obtained an amelioration. The result of this practice, in cases where iodine is not indicated, is that it acts simply as a palliative with all its inconveniences, namely, that the patients are obliged to take enormous and increasing doses of the drug in order not to have an attack come on with all its violence. The sufferings caused by the pushing of the iodides to their extreme become insupportable, and patients come to regard the return of the attacks as preferable to continuing the use of the remedy. The pathogenesis of this drug gives us a picture of long-lasting dyspnoeic attacks, accompanied with an afflux of blood, to the upper parts of the body. The presence of chronic emphysema is of great value, as an indication for the iodide of potash, in asthma. The writer prescribes, ordinarily, 2 grams (30 grs.) of the iodide of potash in four ounces of water. The patient is to take two teaspoonfuls of this preparation per day.

Mineral Waters.—The waters of Mont-Dore and those of Caunterets are especially indicated; they have been found very efficacious.—*L'Art Medical*, No. 12, 1891.

DR. MACFARLAN'S PROVINGS AND OBSERVATIONS WITH THE HIGH POTENCIES.—*Lachesis* 16m, has cured for me a great number of cases of chronic sore throat, dryness in throat, often raw or sore, with much swelling. After producing throat symptoms in a young man, it caused severe pains all over his head, back and front. Giddy, could not stand, had to be carried from school; couldn't see the letters in his book; fell against the wall, etc. These occurred on the fourth day; never so affected before. Cm quickly curative in cases of delirium tremens, where there is much trembling and confusion of ideas. Given every one-quarter of an hour for three days produced frightful constrictive sensation at the larynx; almost suffocated at night. In an attack awoke the whole family; they poured a quantity

of brandy down her throat with but little effect. Although she was dying from inability to breathe or expand her lungs, sat up in bed struggling for her breath, like an asthmatic. *Cm.*, in a woman at forty-five, produced rolling from side to side in the bed constantly, from hour to hour. Could not stop her; extreme restlessness and nervousness. Lachesis every quarter of an hour apparently cured a case of membranous croup in its last stages. Coughed up pieces like a cast of bronchus and was relieved in two hours. The 6th produced in several young persons very sore throat. *Cm.* has cured repeatedly diphtheritic sore throat and has been of great service in malignant scarlet fever with very offensive breath; glands of neck swollen; soreness of neck to touch; suffocative attacks as soon as anything touches the larynx. Even the front part of the throat is sensitive, has to loosen everything around the neck to breathe better. *Cm.* caused suffocative sensation; distress on either side of sternum at its middle. *Cm.* cured hoarseness with complete loss of voice very many times.

Lactuca virosa 5c.—Right eye smarted a great deal; pains catch him in the lungs, back and front; pains across the top of the sacrum.

Lamium 1m.—Severe sick headaches in the morning, giddy, worse on left side; muscles generally sore, as if the prover had taken cold; muscular and mental exhaustion, with no inclination for food.

Laurocerasus cm. helped cough and greatly lessened the chronic expectoration in persons of consumptive tendency; produces a short, dry hack, or clearing of the throat in others not previously so affected.

Lithia carb. 5c.—Have found it highly curative in barber's itch, circular, moist, furfuraceous patches on the skin; porrigo. 5c caused a rough rash all over the body, much loose epithelium; tough, dry, itchy skin; turbid urine. 5c caused: Skin of the whole body dry and rough; the face or rather both cheeks were covered with dry bran-like scales. This was produced on several infants to whom I had given the medicine for some time.

Ledum 45c.—Gnawing headache in temples; headache of back of head and ears; talking in sleep; nausea; confused vivid dreams.

Lilium tigrinum 45m.—Compelled to pass water frequently, with burning sensation; feels bruised about the genitals; bowels that were costive move more regularly; smothering sensation in the chest; feels like vomiting when she touches her epigastrium. Feels as if she must cross her legs for fear everything in pelvis would be pushed out. Her head feels confused and heavy; glands on left side of neck slightly swollen and painful.

Antirrhinum linaria 30x and lower.—Fainting spells occurring three or four times a day; fainted dead away; never occurred before. The prover was rather a weak individual, disposed to phthisis, fainting without any other symptom; attacks of weakness and fainty feeling from probable disturbed heart action, due to the medicine. Frequently verified this.

Linaria.—Gathered the flowers of antirrhinum linaria myself and made the potencies 3d to 30th; taken in water, given every hour or two. Giddy, sick stomach, perspiration, rumbling of gas, bowels somewhat loose, vomited several times on fourth day. No urinary symptoms produced as I expected.

Lobelia 45m.—The oppression is felt in the throat. Sick stomach with ptialism.

Lycopodium 45m.—Highly curative in gall-stone colic. The attacks were painful while they lasted: medicine generally relieves quickly. Verified this repeatedly. 45m; I believe I am indebted to this medicine as a means for the cure of pneumonia in my child when two years old. It has often acted like magic in the relief of bronchitis of young children especially. 45m acts in a wonderful way in curing acute bronchitis of children. Great rattling of mucus in the chest. Chest oppressed; breathing rapid, cough frequent and loose. 45m; child frequently awakes at night and rubs her nose so much and long that the parents are astonished. Have frequently verified this symptom. 45m caused symptoms of cold in the head; verified in many cases. 45m caused sniffles in children; symptoms of influenza. 45m remarkable in relieving the short and painful breathing of pneumonia.

Mentha pip. 5c.—Pharynx inflamed; produced very sore throat, not swollen, simply dryness and redness; griping pain in median line, below the umbilicus (4m); bowels a little loose, simply griping.

Mephitis 1m cured frequently very severe, hoarse, hollow, deep cough, with soreness in the chest (often verified); convulsive, teasing, tickling cough, without expectoration.

Mercurius corrosivus 5c.—Curative in constipation, with so-called bilious condition;

sensation as if the mouth was scalded; soreness of mucous membrane; frequently curative in bloody, painful diarrhoea of a chronic kind, dysentery, colic, rectal pains. 5c. After trying many remedies, this was the only one which cured bloody, frequent, offensive stools, mixed with mucus, with great pain in the abdomen.

Left testicle swollen, or sensitive in some cases, soreness at sides of the waist, general weakness, no strength to work properly, left hypochondrium worse than the right.

Merc. protiod. 2c.—Given to cases of hard chancre caused a number of pimples to appear, changing to pustules resembling small-pox. In children produced frequent green stools. 2c., constant tendency to hawk and spit. Pressive pain in the forehead, worse at night, feels as if bruised all over, especially thighs; passes water seldom, but in very large quantities; it soon becomes turbid on standing. Feeling as of a great ball in the epigastrium. Frequently cured the symptom of urine turbid from excess of urates and being alkaline.

Mercurocum 103m.—Highly curative in severe nervous headaches through the temples. Pains shooting through the eyeball to the back of the head. One of the best remedies in violent ciliary neuralgia, either from disease or after operation; relieves the pain in glaucoma.

Muriatic acid 5c.—Heat on top of head, piles, wants to lie abed, so tired; slight neuralgia on left side of head, slightly sick at stomach, some diarrhoea and pain in the bowels.

Myrica cerifera 45m.—Mist before the eyes, appearance as if of a flame before them. Can't see well. This remedy has not been proven enough to place much dependence upon the symptoms.

Myrtus communis 5c.—Rheumatic pains in the armpits and shoulders; severe joint pains. Promptly relieved and cured distress and bearing down sensation in uterus with ovarian soreness.

Natum mur. em.—Caused buzzing in ears in a number of cases. Has cured a great number of cases of fever and ague given in water, every two hours or eight times daily. Had a wonderful effect in restoring vision in chronic asthenopia. Cured symptom of spots in field of vision. Caused sores in mouth resembling aphthae, often verified.

Nitric acid 5c.—Eyes weak, great soreness along the tibia, periosteum sensitive, had to wrap flannels on the legs to relieve the pain; piercing pain in the temples, sores all around the mouth like small fever blisters. Oppressed chest, pain across both buttocks, throat slightly sore, gums sensitive, margin on the mouth covered with sores, rash over her face and forehead, small pimples, no appetite, vomits occasionally, bowels move twice daily, eyes excessively painful and felt too sore to use much, head feels hot; legs (left more than right) very sore in front from ankle to knee; within the nostrils sore. Rapidly cured cases of syphilitic ulcerated sore throat, syphilitic white patches in the mouth, and many cases of chronic syphilitic ulcerations in various parts of the body where iodide of potassium had been given without effect.

Nitrum 5c.—Disposition to bite the lips; a nervous affection, crackling and clicking in ears. Arrested most violent attacks of asthma; relieved spasmodic breathing in heart affections. Cured a number of cases of painful menstruation, chronic cases, when the flow is delayed and scanty; uterine colic.—*Homœopathic Physician*, February, 1892.

ARGENTUM METALLICUM.—This drug produces a tendency to spinal irritability, spasms of muscles, attacks occurring at noon. Also produces a tendency to paralysis, anæmia, and oedema. It acts on mucous membranes, producing a catarrh, especially of the mucous membranes of the pharynx and larynx, with an expectoration of clear, transparent or gray viscid mucus, which strongly resembles *boiled starch*. The throat becomes raw, rough, and sore from hawking up this gelatinous mucus. This is of a subacute or chronic form, and is familiarly known as singers' or ministers' sore throat.

In the *urinary organs* metallic silver has modified diabetes mellitus and cured diabetes insipidus. It has sweet smelling urine and pain in the right testicle. Rhododendron and Aurum also have these symptoms, and in this respect "Silver may be said to be on a par with gold." In woman there is pain and swelling of the left ovary. It is a good remedy in chronic blepharitis, the lids being, red, sore, and thickened, with but little secretion.—Abstract of Lecture by T. F. Allen, M.D., from the *Chironian*, Feb. 20, 1892.

ARGENTUM NITRICUM.—*Argentum nitricum* produces more violent action on the nervous system than does metallic silver. It produces the same symptoms as appear in epilepsy, tetanus and paralysis. The *pain* of *argentum nitricum* is due to the HNO_3 which it contains, and so is sharp and sticking.

The tissues of the body have been known to become blue-black from the constant use of *argentum nitricum*. It is often indicated in epilepsy produced by fright, and in chorea brought on by the excessive use of alcohol; also in post-diphtheritic paralysis when the diaphragm is involved, as in locomotor ataxia.

Internally or locally used, it produces inflammation of mucous membranes, with a purulent secretion. The sub-mucous tissues also become swollen and the accompanying pain is sharp and sticking.

In urethritis, if seen early, when the membrane is red and hot, but as yet no secretion, *acon.* should be given. If on the following day there is a *profuse purulent* discharge, the mucous membrane being inflamed and swollen to a great extent, AgNO_3 is well indicated; but if there should be smarting and heat, with but *little* pus, give *cannabis sativa*, in from the third to the sixth dilution, for two or three weeks, by which time a cure may be expected.

Gonorrhœa may sometimes prove to be a blessing in disguise, as I believe many a man has been cured of chronic bronchitis, with a tendency to tuberculosis, by having this trouble.

AgNO_3 is a valuable remedy in the treatment of the eye. Purulent ophthalmia in children but a few weeks old may be cured in a few days by the use of this remedy, if cleanliness of the eye be secured.

If AgNO_3 is swallowed, we get ulceration of the stomach, which produces *retching* and great distension of the stomach, but the patient cannot vomit; there are cramps in the bowels, with a tendency to collapse. So this is a good remedy in acute gastric inflammation of drunkards with the following symptoms: An enormous flatulent distension of the epigastric region with tenderness and burning pain, thready pulse, dry, red tongue, tries to vomit but cannot, and tendency to collapse.

AgNO_3 produces a diarrhœa which is green and has much mucus; it is fetid and slimy, as if it were the lining of the bowels, especially of the small intestines; there are flakes of mucus and blood, so it is sometimes indicated in typhoid fever when there is a great deal of flatulence. The aggravation is at *noon*.

Both AgNO_3 and *Gelsemium* are indicated in diarrhœa produced by fright. In *recent* fright, when there is no pain and but little flatulence, *gels.* is the remedy. AgNO_3 is indicated in chronic cases, when the discharge is more or less bloody and there is pain in the abdomen and great distension. AgNO_3 has arrested locomotor ataxia, in its early stages, with the symptoms of easy palpitation of the heart, irregular movements, especially of the legs, with heaviness and pain in the back.

In closing, Prof. Allen cited the case of a man suddenly becoming blind, perhaps from hæmorrhage into the optic nerve, who seemed to see a landscape dotted here and there with trees, about which were coiled snakes. The imaginary sight of snakes, even in those not intoxicated, is a strong indication for AgNO_3 . —*Ibid.*

THREE CIMICIFUGA CASES.—Dr. A. Pfander, reported the three following cases among others, at the autumnal gathering of the Swiss Homœopathic physicians, held November 1, 1891: 1. Mr. J. G., 50 years of age, was attacked with violent rheumatic pains in the back of the neck; allopathic treatment relieved him but little. Soon after he was seized with severe pains in the neck, which radiated out toward the face, upon both sides. They seemed apparently to concentrate upon the vertex, to be continued to the eyes. Moving the head backward gave some relief, as well as leaning the head against any hard substance. The pains were especially severe of nights, and distinctly so after midnight; toward noon it decreased to increase somewhat in severity during the afternoon. Speaking and mental exertion caused the pain to reappear. He had a feeling as though he had a tight cap upon his head. He had been treated in vain by allopathic physicians with antifebrine, antipyrin and phenacetine. The writer gave him *gelsemium*. Two weeks after he was no better; as he spoke with him he noticed that an attack of pain came on while his face flushed up. He gave him accordingly *glonoine* 6x, every two hours. Two days after his condition had somewhat improved. He remained for two days about the same. *Glonoine* 3c. Four days after the patient

awoke without any pain, for the first time ; at noon and during the afternoon he had a moderately severe attack. The nights were passed without pain. The next three days were passed in comparative comfort, the attacks being less severe. He received glonoine 3 and cimicifuga 3. He continued to improve under the influence of cimicifuga alone finally, in the course of a week after he was freed entirely from his disease.

Mrs. K., 41 years of age, complained of rush of blood to the upper portions of the body before the appearance of the menstrual periods. Hæmitemesis. Anxious feeling in the head, with heat, was complained of; the menses were too early and too profuse. She had a sensation as if she had a tight-fitting cap upon her head, with heat in the vertex. Cimicifuga 12x, morning and evening. These symptoms soon disappeared. The symptoms which led the writer to choose cimicifuga was the feeling of a cap of a cover upon her head, with the accompanying sensation of heat.

3. Mrs. T., 45 years of age, has suffered for several years from migraine, especially at the time of the menses ; attacks have also appeared during the intervals. It usually begins in the morning to gradually increase towards the evening, and usually lasts twenty-four hours. It may also come on in the afternoon and last until 6 o'clock the next morning. The pains are located in the right temple or extend into the right eye, or even the back of the neck. This is accompanied by a feeling as if the head was surrounded by an iron ring and intense heat. Reading tires her very much ; especially of mornings is she very sensitive. The menses are irregular and accompanied by extreme exhaustion. Cimicifuga 30x, mornings and evenings. Three months later he heard from her and was informed that the migraine was much better and had come on but once in two months, while before she would have an attack every two or three weeks. It was also less intense.—*Allgemeine Homœopathische Zeitung*, Nos. 1 and 2, 1892.

A STUDY OF COCCULUS INDICUS.—Dr. Gertrude E. Heath after thoroughly analyzing the provings of *cocculus* gives the following summary of the symptomatology of the drug :

Mind.—Anxiety ; cheerful and contented ; excessive irritability and sensitiveness ; trifles offend.

Head.—Confusion of head ; vertigo ; vertigo as from intoxication ; sensation as if the brow was constricted or compressed by a band ; pressive headache in the crown ; pressive pain in the forehead ; pressive pain in the right side of the forehead ; pressive pain in the left temple.

Eye.—Dull pressure in the eyes.

Nose.—Sneezing.

Mouth.—Dry sensation in mouth ; nauseous taste.

Throat.—Dryness of throat ; swollen, hard glands beneath lower jaw ; profuse accumulation of saliva.

Stomach.—Hiccough ; nausea ; loss of appetite ; aversion to food ; great thirst ; frequent eructations ; vomiting ; pain beneath pit of stomach.

Abdomen.—Distension of abdomen ; flatulence ; pain in abdomen ; pinching in abdomen ; stitches in left side of abdomen ; stitches in right side of abdomen ; colic.

Rectum and Anus.—Threatened hernia ; pain as from hernia ; urging to stool in the rectum ; soft stool ; frequent small diarrhœic stools ; constipation for several days.

Urinary Organs.—Urging to urinate, with pressive pain in the urethra.

Respiratory Organs.—Rapid and difficult breathing ; dyspnœa.

Chest.—Stitches in chest and region of sternum ; stitches in left chest ; stitches in right chest ; oppression of chest as if pressed against by a blunt instrument.

Neck and Back.—Pain in the cervical muscles, worse on moving the head ; pain in the region of the scapulæ, worse during rest ; pressive pain in the back.

Extremities in general.—Limbs heavy and stiff ; paralytic drawing pains in limbs and back ; painful lameness of the joints.

Superior Extremities.—Sticking pain in the left arm ; pain in the upper arm ; cramp-like pain in the fingers.

Inferior Extremities.—Lameness of left thigh ; drawing pains in the limbs, worse from motion.

General Symptoms.—Clonic spasm ; loss of consciousness.

Skin.—Itching and burning here and there ; pimples, painful to touch.

Sleep.—Frequent waking from sleep as from fright.

Fever.—Creeping chilliness over the whole body; increase of temperature; flushes of heat in the face.—*Transactions of the Maine Homœopathic Medical Society*, vol. v.

VERIFIED SYMPTOMS OF LYCOPODIUM.—Cough aggravated night and morning, and by lying on the right side, also on alternate days.

Vertigo dependent upon gastric troubles; the patient eats but little before feeling full. There is a hot feeling at the stomach. The patient is irritable. In men who are overworked mentally. Bowels full of gas, with colicky pains in the bowels more to the right side. Constipation. Palpitation of the heart after eating.

Catarrh of the stomach of long standing.

In chronic liver troubles with yellowish look of the face, and feeling at stomach as if hot water was in it, with irritability, lycopodium 6x cured.

Fanlike movement of the alæ nasi. In a case of typhoid fever that seemed helpless, with the patient unconscious, the fanlike movement of the wings of the nose was marked. Lycopodium 30 cured.

Putting the tongue out of the mouth and moving it from side to side.

Feeling as of a tape around him; backache relieved by passing water; brick dust sediment in the urine.

For pain extending from the right kidney over the right hip as a symptom of renal colic, lycopodium 6 or 30 has worked nicely.

Chronic rheumatism of the hands of years' standing; pains aggravated at night.

Rheumatism relieved by motion. In a bad case of sciatica of the right side in a man aged 58, sometimes he would awake at night with a violent twitching of the right leg, with pains streaming from hip to feet.

Two cases of eruption of red itching pimples on the neck.—Dr. C. M. Foss in the *Transactions of the Maine Homœopathic Society*, vol. v.

VERIFIED SYMPTOMS OF KALI CARB.—Catarrh; tough mucons in back part of throat, difficult to hawk up; constant hemming; feels as if something must come up; the irritation is constant.

Cough and tickling in throat and bronchi, hard to start any expectoration, with gagging; what does start, often has to be swallowed again; can feel the tough mucus move up and down.

In the case of pneumonia with the right lung hepatised, with amelioration by lying on that side, cough aggravated after midnight, kali carb. acted quickly.

In one case with pain and tenderness over the liver after a blow upon that part, having an amelioration by lying on the painful part, kali carb. 3x relieved after bryonia and arnica failed.

In capillary bronchitis in children with sibilant rattle over both lungs, but with the rattle more over the right, with difficulty of getting anything up, kali carb. helped after tartar emetic failed.

In a case of phthisis in a young lady, having sharp stitching pains in the right lung when coughing and at other times; the cough aggravated after midnight with scanty expectoration of bloody matter; with the experience of quite a number of pulmonary hæmorrhages; with a pulse of 120° and a temperature of 103° kali carb. 4m relieved at once all of the symptoms, so that the patient again got about. She died a year later from pulmonary hæmorrhage.

Night sweats with bronchitis.

Cough with spasmodic and suffocative spells. After coughing awhile would start a little tightly adhering mucus from the tubes.

The arms and hands go to sleep easily. A lady aged 62 years awakes every night after midnight with arms and hands so numb that she cannot move them for awhile; fingers feel as if asleep until morning. Kali carb. 6x cured.—Dr. C. M. Foss, in the *Transactions of the Maine Homœopathic Society*, vol. v.

VERIFIED SYMPTOMS OF PTELEA TRIFOLIATA.—Sharp cutting pain; cutting in the region of the liver, better by lying on the painful side. A lady aged 40, of a bilious temperament suffered from violent pain in the stomach and through the liver, with tenderness of the parts, and bitter vomiting. She would awake at night with violent pain, which was ameliorated by lying on the painful parts. Bryonia relieved her but the patient got worse, the liver became swollen and very painful. Ptelea 2x cured very promptly.—Dr. C. M. Foss, in the *Transactions of the Maine Homœopathic Society*, vol. v.

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HYOSCYAMINE AND HYOSCINE IN NERVOUS AND MENTAL DISORDERS.

BY E. M. HALE, M.D., CHICAGO.

THE cases I shall narrate, will show that while hyoscyamine is valuable, hyoscine is without doubt the active principle of hyoscyamus, which we should use, when we do not use the crude drug itself. It is pleasanter in its action than hyoscyamine, and less likely to cause pathogenetic symptoms.

I cannot forbear calling attention here, to the singular tactics of our colleagues of the so-called regular school, particularly in relation to their use of this drug. Not one of them is now ignorant of the fact that the law of *similia* is a therapeutic law, but it galls him to admit it.

They prefer to stultify themselves by calling it by some other name. A prominent physician, who has charge of one of our largest insane asylums, in reporting his experiences with hyoscyamine says: "This drug seems to possess the singular power of *substituting* its cerebral symptoms for those existing in the insane to whom it is administered. He goes on to say that when the patient comes under the action of this drug, his previous hallucinations pass away. But when he comes to describe the illusions and symptoms cured by hyoscyamine, they can all be found in our pathogenesis of hyoscyamus."

Another English alienist says of hyoscyamine: "It has undoubtedly an alterative influence in cerebral affections, and certain insane

illusions and hallucinations, *especially when the patients are destructive, jealous, and suspicious.*"

Hahnemann himself could not have better described the indications for hyoseyamus.

Now the above quoted authorities as well as others whom I might quote, know well enough that they are guilty of evasion, and a contemptible "dodging the truth." Why cannot they in such cases, adopt a manly and honorable course, and frankly admit that the drug acts in such cases in accordance with the law of *similia*, even if they do not believe in the general application of that law?

Several years ago, when hyoseyamine was first introduced, a patient was brought to me from a distance, in the hopes that she might get some benefit from medicine. If not, her relatives were resolved to place her in some insane asylum. She was a woman of middle age, of robust physique, and in apparent good physical health. A year previously, she had become suspicious of her husband's fidelity and of his affection. This suspicion extended to many of his and her own relatives. She lost all interest in her domestic affairs, and became morose, with occasional attacks of destructive mania. For these and other symptoms I suggested hyoseyamine, although Dr. Whitman, her medical adviser, had given her hyoseyamus 3d and 6th. I advised 3d trituration of the alkaloid one grain three times a day. In a few weeks Dr. Whitman reported by letter that the patient was herself again, having lost all of her insane delusions.

I have on record several similar cases which were cured with this alkaloid.

During the winter of 1892, a physician who was not then in practice, brought his wife to me for consultation. They had been married but a year, which had been a happy one, until a few weeks previous to the date of consultation, when she began to have suspicion of a conspiracy among his friends to alienate her husband's affections from her. She had no doubt of his fidelity, or of his affection for her, but she believed that certain persons were conspiring against their domestic happiness. If she found any one or more of those persons had been with her husband, she would become enraged to such extent that she would bite, scratch, and attack her husband with violence, and use abusive language. Such attacks would end in a hysterical paroxysm, followed by prostration and stupor, after which she would be very penitent.

I found her uncle had been an inmate of an insane asylum, and that her two sisters had had symptoms similar to her own. There

were no symptoms of any physical disease whatever except scanty menses, but her symptoms were not aggravated at the menstrual periods. My prescription was: A dose of the $\frac{1}{500}$ of a grain of hyosine three times a day.

After she had taken it a week, she called and reported that all her hallucinations had disappeared, and that she felt very happy and buoyant. Two months have elapsed, and her symptoms have not returned. She only continued the medicine a few days. I omitted to say that in both cases, the first symptom of improvement was a removal of a *sleeplessness*, which was a prominent symptom.

As a remedy for insomnia, it has lately come into high favor with the allopathic school. But here, again, they are very careful to prescribe it according to the law of *similia*.

Dr. Kuy, of Strasburg, reports the results of the administration of the muriate of hyosine in 88 different cases occurring in the Strasburg clinic for nervous diseases. In 82.2 per cent. the result was successful, sleep lasting from 6 to 8 hours, occurring within an hour after the dose was given.

The majority of failures occurred in cases where the insomnia was *not* accompanied by any *motor disturbances*; while, on the other hand, where there were marked motor symptoms, as in mania, with great excitement and paralysis, the result was most favorable.

This is in accordance with our leading indications for hyoscyamus, which are "insomnia, with great mental and physical excitement, hallucinations, illusions, jerking, twitchings, etc." Now, if the drug was *antipathic* to insomnia, it would cause just the opposite of these symptoms in healthy persons, which it does not and never can, unless a lethal dose is given.

In a case reported by Dr. Gibb, $\frac{1}{50}$ of a grain caused "mild and active delirium, of a loquacious character. He would grasp imaginary objects, talked incessantly, and was with difficulty kept in bed." This does not look antipathic!

In another case, after the $\frac{1}{15}$ part of a grain, reported by Dr. Morton, there were "clonic convulsions of arms and legs, followed by a tetanic condition," which does not seem antipathic to "insomnia, with great mental and physical excitement."

In a case reported by Dr. Prentiss (*Therapeutic Gazette*), a woman was given $\frac{1}{100}$ grain. In three minutes there was great dryness of mouth and throat; flushed face; a nervous, quivering sensation all over the body; delirium; crying bitterly; very nervous!

Without further citations, it is the testimony of the old school that

hyoscine is most successful in insomnia, insanity, paralysis agitans, delirium, etc., the nearer the symptom of the patient approaches to the symptom of the drug.

We know that one of the chief indications for hyos. is aggravation of the mental and nervous symptoms at *night*.

Scheussner (allopath) reports that in his clinic, "attempts to calm excited patients *in the day-time* were failures."

This is a decided confirmation or verification of that indication. H. C. Wood (*Therapeutic*) says: "The *insomnia* which is especially relieved by hyoscine is that which is connected with cerebral excitement when sleep is banished by a continual whirl of thoughts and mental images." Just so. Hahnemann says the same.

I have for nearly two years used the hydrobromate of hyoscine instead of hyoscyamus in all cases of nervous and mental disease, and I am more sure to get curative effects.

The tincture of hyoscyamus is liable to be of uncertain strength, and sometimes almost inert. Method of administration: Continental physicians at first gave it hypodermatically, but soon discovered that the internal administration gave better results. The effects lasted longer, and many unpleasant symptoms were avoided.

The maximum dose used by the regular school is $\frac{1}{80}$ grain, but this is considered too large; by those who use it most the $\frac{1}{100}$ is considered safe, yet cases of poisoning have occurred from $\frac{1}{100}$, and even from the $\frac{1}{250}$ grain.

It is never necessary nor proper to cause a single pathogenetic symptom. I consider the $\frac{1}{500}$ grain of any of the salts of hyoscine to be the true maximum dose. The minimum dose—the dose which cures best—is only to be ascertained by careful observations. I usually begin with $\frac{1}{1000}$ grain, *i.e.*, 1 grain or 1 drop of the 2c attenuation, and increase the dose until I get curative effects, or fail to relieve the patient. The dose need only be a single one for insomnia; or every 4 to 6 hours in insanity.

CHROMIDROSIS AFTER THE ADMINISTRATION OF IODIDE OF POTASH.—G. H. Temple reports the case of a man, *æt.* 60, suffering from tertiary syphilis, who daily took three doses of iodide of potash of two and a half grains each for eight days. After the lapse of that time the hair of his head and beard, which had been white, became a pale rose red color. His underclothing and his handkerchief with which he wiped off the perspiration also became distinctly red. When the remedy was stopped for a time the red coloration gradually disappeared, to return again when the administration was resumed.—*Monatsshefte für praktische Dermatologie*, Bd. 13, No. 11, 1891.

A STUDY OF THE ACTION OF SULPHONAL, PREPARED WITH THE
VIEW OF INTRODUCING THE DRUG AS A HOMŒOPATHIC
REMEDY.

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THE great length of this communication debars me from making certain preliminary remarks which I would like to present concerning the vexed question of *materia medica* investigation in general. Justice to my readers requires me to treat of my subject as speedily as possible, present the data to which I wish to call their attention, and draw my conclusions. In the preparation of this study of sulphonal, I have gone carefully over the periodical literature of the drug, and have found a moderately large number of reports of cases of sulphonal poisoning. I have also found a number of reports of experimental investigations into its action. It is these reports that I have incorporated in the following observations. When the original source of the publication of the poisoning or experimental investigation was at my disposal, I prepared the abstract for this article myself; but in those cases in which the original publication was made in a foreign language, I have been obliged to rely upon abstracts in English and American journals, which abstracts are here presented in almost the exact language of the translators. I could have made the paper much shorter by omitting these gleanings from literature, giving my readers only the symptomatology of the drug as schematically arranged; but this course, it seemed to me, would greatly lessen the value of the paper. Every one cannot be expected to draw the same conclusions that I have done, nor can any one judge of the correctness of what is here given him unless he has all the data leading to the results attained. Furthermore, I think, the proper understanding of the action of sulphonal can only be obtained by a study of the individual cases of poisoning by this drug.

One thing that will be at once noticed concerning the following observations as culled from medical literature is, that all the patients on whom the action of sulphonal is reported were sick. This fact alone would be sufficient of itself to invalidate all symptoms of the drug were it not that the different observations show a most remarkable concordance of results, notwithstanding the great variety of pathological conditions noted in the patients to whom the remedy was administered.

The report of this large number of cases of sulphonal poisoning might seem to be a severe arraignment of the drug as a hypnotic. This, I think, is a mistake; for while sulphonal, like many other drugs, has, when given in improper manner, produced deleterious effects, it has, when administered properly, been productive of good results in many instances. Sight must not be lost, also, of the fact that some observers make claim for having used sulphonal in several hundreds of cases without once meeting with even one unpleasant symptom that could be traced remotely to the drug. This paper was not prepared for the purpose of either praising or condemning the action of sulphonal as a hypnotic, so I shall not delay longer with this phase of the subject.

One cannot help but be struck when studying the following observations that the individuality of the observers stamps itself thereon. While, as above stated, some physicians have claimed to have given sulphonal in no less than 400 cases without once noting a bad symptom to follow, others, with much less experience, like Griffith, Shivers, and Smith, hereafter quoted, report 9, 3, and 5 cases of poisoning respectively. The conclusion is irresistible that he who gave the drug in 400 cases was so anxious to get sulphonal into as many patients as possible, that he neglected entirely to note any of the after-effects of the drug.

The fallacy of studying *materia medica* as presented in schematically arranged symptomatologies is, I think, glaringly shown in this paper. In the preparation of the schema which here appears, I have affixed to each symptom the number of the observation in which it was noted. My readers will note that but a small number of the symptoms were found in many cases. Vertigo, ataxia, headache, nausea, vomiting, and mental symptoms are the only ones noted many times. Again, studying the mental symptoms disconnectedly, but little valuable information is obtained. If, however, we study the individual provings, we find that the general picture of one corresponds with that of many others to a most remarkable degree.

Some of the symptoms seem to have been observed only in more recent months; and having been observed in one, they are searched for and found in other cases. As an illustration, we have the symptom hæmatoporphyrinuria.

With these remarks, then, I present the following observations of the toxic action of sulphonal:

OBSERVATION 1.—Dr. J. M. Loeb1 prescribed thirty grains of

sulphonal in two doses to a woman who complained of sleeplessness. When he called two days later, he found the patient in a lamentable condition. She stated that after the first powder she did not obtain sleep, and on the following day was somewhat deaf. In the evening she took the second powder. After a restless night, in the morning she felt intense dizziness, headache, nausea, sensations of heat and cold. Every effort to rise induced nausea. The skin was cool and the pulse 55. After the patient had taken tea and rum, the pulse rose gradually to 70, though the remaining symptoms lasted the whole day and a greater part of the night. It was afterwards learned that the patient was menstruating, and to this Dr. Loebel was inclined to attribute the whole disturbance; but the patient declared positively that she had never been so affected before, and attributed the condition to the hypnotic.—*Wien. Med. Presse*, January 20, 1889.

OBSERVATION 2.—Dr. Paul Rehm reports three cases in which the use of sulphonal was followed by unpleasant results.

(a) CASE I.—A lady, aged 48, took 1.5 grammes of sulphonal every night for six successive nights. It acted well the first three times except that she felt tired and used up. After the remaining doses there occurred constipation, loss of appetite, extreme bodily and mental restlessness, agitation, anxiety, confusion, and with the eyes closed, the feeling as if the bed swayed; with open eyes, illusions, and hallucinations of a sad character, and depression. The patient appeared stupid, and lay as if paralyzed; the face sallow; the eyes without expression, pupils contracted; speech hardly audible, her tongue being as if paralyzed by an apoplectic attack; pulse 100 and weak; respiration normal. There were also ischuria; great hyperæsthesia; double vision; muscular contractions; restlessness of the limbs; a peculiar disturbance or sensation, causing her to assert that she has four legs; sensations of heat and cold, and mental confusion; sitting up was impossible; the motion of the hands was impossible; the eyelids could not be raised. Cessation of the use of sulphonal resulted in immediate improvement, but only after four weeks was she able to take a few steps alone.

(b) CASE II.—A gentleman took two grammes of sulphonal. He had a good night but did not lose consciousness, and it seemed as if the bed swayed. During the next day he lay stupid on the sofa; had no appetite; was nauseated and vomited several times and felt giddy. Subsequent trial of sulphonal brought the same results.

(c) CASE III.—A lady aged 32 years, for years a moderate user of morphine now and then slept badly. She took a two-gramme dose of sulphonal. For four days afterward she felt tired, sleepy, stupid and giddy; that the bed seemed to move, and she felt that she must walk with one leg over the other.—*N. Amer. Journ. of Hom.*, July, 1889; quoted from *Berl. Klin. Wochenschr.*, 16, 1889.

OBSERVATION 3.—Dr. Max Engelmann reports the case of a patient aged 42, who at the time of the menses took thirty grains of sulphonal. It had no hypnotic action. Towards morning there

was moderate itching, and the appearance of a scarlet exanthem upon the outer site of each mamma. The exanthem was distinctly limited from the unaffected skin. By the next night the exanthem had extended to the inner side of each arm and also towards the sternum. On the third day the eruption which was now the seat of violent itching, gradually disappeared. It has been noted by Lesser that the majority of cases of drug eruptions are to be explained as attributable to vaso-motor disturbances, a theory which in this case appears to be sustained by the perfectly symmetrical character of the eruption.—*Med. and Surg. Reporter*, February 2, 1889, from *Therap. Gaz.*, January, 1889.

OBSERVATION 4.—Dr. Schotten, in Cassel, reports the case of a delicate nervous woman, 45 years of age, suffering from chronic myelitis who, for one year, had regularly taken chloral on retiring. On the night of August 29th this patient was given thirty grains of sulphonal. It did not produce sleep, but rather a sense of fatigue. The following evening thirty grains more were administered with the same result. On the third evening forty-five grains were administered. This was followed by prolonged sleep, but on awakening the patient complained of a peculiar feeling of extreme fatigue, manifested by great inclination to sleep, hanging of the head, and difficult motion of the tongue; besides this she complained of headache, bitter taste, and loss of appetite. This condition lasted four days, after which time an exanthem made its appearance, beginning on the head and gradually extending over the entire body, resembling in form and color the eruption of measles. The lesions were bright red macules the size of lentils. These in many places formed larger macules by their coalescence, and at their centre presented a papule which had its origin in a follicle. The body was hot; the skin had a burning sensation; the mucous membranes were not affected. With the appearance of the eruption the sensation of fatigue, etc., gradually disappeared. The exanthem lasted two days, after which it gradually disappeared.—*Wien. Med. Presse*, 52, 1888.

OBSERVATION 5.—Dr. Ullman reports the following cases: (a) A man 34 years of age, who had been taking morphia and cocaine to excess, swallowed a quantity of sulphonal to allay the uncomfortable effect produced by the cocaine. When seen he had the appearance of a man intoxicated with alcohol; a heavy look about the eyes, a reeling gait, stammering speech, and an erratic gesticulation. When spoken to in a loud voice he attempted to respond in a half articulate fashion, as though the tongue was paralyzed. The moment afterward the head sank on the pillow and the patient fell asleep. In four or five days the severe symptoms disappeared, and the sleeplessness gave place to restlessness, the intellect becoming clear.

(b) A patient took four or five grammes to produce sleep. Symptoms of poisoning suddenly set in. There were ataxic symptoms, uncertainty of movements and complete incapacity to walk. The ataxic movements were seen mostly in the legs, the arms and tongue

being but slightly affected. The symptoms disappeared in a few days.

(c) Motor disturbances of the tongue and lower extremities followed the administration of sulphonal in doses ranging from one to four grammes every evening for eight months.—*Manchester Medical Chronicle*, vol. xi., p. 259.

OBSERVATION 6.—A patient suffering from chronic metritis, was extremely debilitated by absence of appetite and want of sleep. Fifteen grains of sulphonal at bedtime acted well for awhile, but finally failed to induce sleep, and only caused great restlessness instead. Finally a second dose of fifteen grains was given four hours after the first. The patient then fell asleep. In the morning she was unable to rise. She complained of giddiness, of being unable to hold the head up, and could not stand or walk without assistance. There was vomiting and the stomach refused to retain food for many hours. When permitted she slept a troubled uneasy sleep for the entire day. It was not until the end of the third day that she felt herself again.—Reported by C. M. Rexford, M.D., in the *Medical Record*, March 30, 1889.

OBSERVATION 7.—This and the three succeeding are reported by Dr. A. G. Browning, of Maysville, Ky. A man, aged 40 years, took ten grains every hour for four hours. The result was fidgety wakeful night, worse than before, with giddiness, nausea, and general wretched feeling. The following night he took forty grains at one dose. Four hours afterwards he talked wildly, had tremors, finally becoming so ugly as to compel restraint. Then gave fifteen grains more. Up roar continued until early morning, when he fell asleep. He rested well until afternoon. Friends then became alarmed; patient in a stupor from which he could be aroused, but was somewhat incoherent, and promptly lapsed into stupor; cyanosed and some stertor; with help came slowly around, but was confused, dizzy, and generally uncomfortable for two or three days.—*Medical Record*, July 20, 1889.

OBSERVATION 8.—Young man; feeble development, and anæmic always; troublesome insomnia. Took twenty grains of sulphonal, and two hours later twenty grains more; no effects, early or remote. Gave forty grains early next evening. After four hours there was excitement, which, by twelve, midnight, bordered upon delirium with delusions, and, what was regarded by Dr. Browning as peculiar, harassing and tormenting priapism. On the next day, considerable lethargy, with frontal headache, vertigo, muscular inco-ordination, mental depression.—*Ibid*.

OBSERVATION 9.—A neurasthenic man, aged 42, with insomnia. Was a "genteel" drinker. Was given sulphonal one night without effect; next night took forty grains, and in two hours fifteen grains more. No sleep; but the next day his gait was staggering, as if drunk; he had nausea, vertigo, and frontal headache.—*Ibid*.

OBSERVATION 10.—A colored girl, aged seventeen, was given sulphonal in two doses of twenty grains each within an hour. The

next night, forty grains, and in two hours fifteen grains more. She did not sleep, but was writhing, twisting, and grimacing with chorea in most approved fashion.—*Ibid.*

OBSERVATION 11.—Mr. Jonathan Hutchinson reports the case of a lady who came to him for the removal of an epithelial cancer of the vulva; she displayed a stupid manner, which caused him to look upon her as almost an idiot. After the operation she had retention of urine; the following day she had an erythematous eruption all over her thighs; the skin everywhere becoming of a deep-red tint, without papules or other changes. On the second day after the operation there was an improvement in the patient's manner, and this continued every day until she was bright and cheerful; at the same time she lost the heavy sotted look which she had previously worn. After continuing out for about four days, the eruption disappeared. It was afterwards ascertained that prior to her coming under Mr. Hutchinson's care she had been taking sulphonal.—*Archives of Surgery.*

OBSERVATION 12.—An elderly lady took ninety grains by mistake, and alarming symptoms followed. When seen by Dr. Dillingham, she was in a semi-stuporous condition, passing into a state of stupor, with stertorous breathing. Her radial pulse was almost imperceptible, and extremities cold. Her breathing and stupor soon improved, and her pulse became a little slower and stronger. Inco-ordination of all the muscles was extremely well-marked. Her face was drawn slightly to the right side, and there was ptosis of the right eyelid; pupils were normal. She would doze for a few minutes, then open her eyes, but did not recognize any one. Her articulation was very poor and feeble, and it was with greatest difficulty that her words could be understood. Her mouth was parched, and her tongue dry, and when she put it out it deviated to the right. She had a constant desire to urinate, but passed only a teaspoonful at a time. The urine was normal. When she raised her hands she found it impossible to touch the place she desired. At noon, there was a slight improvement in her condition, though the inco-ordination remained the same. It was difficult to obtain an answer to any question, and even then the reply was incoherent. The next morning, her face was not drawn so much to the right, and the inco-ordination and ptosis had improved. Her bowels were constipated, but there was considerable tenesmus, which was finally relieved by enemata. She was not able to expel the fæces in the lower rectum, and there was paralysis of the sphincter muscle, as she could not retain the enemæ. In the afternoon her mind became clear, but it was with difficulty that she could articulate; she said it tired her so much. The inco-ordination was still marked. She could not use her hands for anything. She tried to write her name but failed. It was ten days before the ptosis, paralysis of the face, and inco-ordination of the muscles entirely disappeared. The paralysis of the bladder and bowels continued for two weeks.—*Medical Record*, Dec. 13, 1890.

OBSERVATION 13.—Bemer reports the case of a man, aged 43

years, of nervous temperament, who had been troubled with various symptoms of neurasthenia, precipitated by heavy losses in business. For over two years sleeplessness had been a prominent symptom, for which he had been taking sulphonal with good effect. In the last five months he is said to have taken ten ounces of the drug. More than four months ago his family noticed a peculiar change in his manner, manifesting itself under the form of apathy and listlessness. He would answer questions put to him after marked and painful delay, as if comprehension was labored and unnaturally slow. Things and persons in whom he had taken the keenest interest became indifferent to him. He made mistakes in his books which it took him a long time to discover; the computation of sums, formerly almost a matter of play to him, became laborious, and was at times impossible; naturally punctual in his habits, he forgot his engagements; in short, his memory and judging powers became visibly impaired, so that his partner suspected beginning softening of the brain, and insisted upon an examination. During all this this time the patient himself had no idea of his mental state, but did not show any surprise at the request to withdraw temporarily from business and undergo a course of medical treatment. One week after the cessation of the drug, the first signs of mental improvement set in, marked by the declaration of the patient that he felt like awakening from a long sleep. After this, recovery was very rapid, there being a perfect realization on his part as to the danger he had passed through.—*Canadian Practitioner*, March 17, 1890.

OBSERVATION 14.—Dr. Geo. Foy prescribed twenty-five grains of sulphonal to a young woman, aged 19, who was suffering from menorrhagia. The dose was given in a state of fine powder at 9 P.M. After undressing and lying down, instead of feeling sleepy, she complained of hearing persons talking to her, and she soon became delirious, holding imaginary conversations with absent friends and strangers. This condition continued until 7 A.M., when she became drowsy and fell into a doze, and remained stupid and lethargic until 10 A.M.—*Medical Press and Circular*, September 11, 1889.

OBSERVATION 15.—According to Henocque, sulphonal produces profound sleep, does not diminish reflex action, and is not an analgesic. A sufficiently large dose causes in animals death from arrested metabolism and depression of temperature. In larger amounts it causes chilliness, vomiting, diarrhœa, cutaneous eruptions, stupor or vertigo. Melancholics complain of hallucinations after its administration; hypochondriacs are depressed.—*Medical News*, March 1, 1890; quoted from *Revue Generale de Clinique et de Therapeutique*, January 23, 1890.

OBSERVATION 16.—Dr. R. R. Pettit, of Dayton, Ohio, reports a case resulting fatally from the administration of ordinary doses of sulphonal. Symptoms are not given with any detail or clearness; antidotes were administered. Death resulted from failure of respiration.—*Medical News*, August 10, 1889.

OBSERVATION 17.—Garnier presents the following among other

conclusions reached from the observation of the action of sulphonal in a large number of cases. 1. Sleep could be induced in nearly every case by doses varying from two to five grains.

4. Out of 100 cases, vomiting was observed in 5.50 per cent., and slight diarrhoea in 17.7 per cent.

5. The above symptoms are sometimes accompanied by dizziness and staggering gait, similar to that produced by alcoholic intoxication.

6. A diuretic action was observed to follow the use of the drug in 17.7 per cent. of the cases.—*Medical News*, August 24, 1889; quoted from *Deutsche Med. Wochenschr.*, June 20, 1889.

OBSERVATION 18.—Dr. Bornemann records the following case of sulphonal poisoning: A physician addicted to the morphia habit, which he had acquired in endeavoring to overcome headache during the past twenty-eight years, and who had visited ten "cure institutions" came at last into the institution of Dr. Bornemann. On the evening of the 10th of May, the patient took for the first time, thirty grains of sulphonal without effect, and it was only after a second dose of fifteen grains, and one-third of a grain of morphia subcutaneously, that he fell into a sound sleep of several hours' duration. May 11, forty-five grains of sulphonal were given at bed-time, without morphia. He slept till morning. May 12, one-third of a grain of morphia, at bed-time, and sixty grains of sulphonal; no sleep. During the same night (1 A.M.) thirty grains of sulphonal; no sleep. Patient left his bed, acted like a drunken man, and fell several times; and when attempting to take hold of an object, he would miss it. Pupils contracted. On the morning of May 11th, patient slept four hours. Even while in bed he believed himself drunk. On the same evening he complained of having two heads, two pairs of arms, and double vision. From that time on, the administration of sulphonal was discontinued, although the patient kept continually asking for it. It was not until May 18th, that all apparent symptoms of poisoning disappeared.—*Medical News*, January 5, 1890.

OBSERVATION 19.—Rochester reports the case of Miss P., æt. 30 years, suffering from exophthalmic goitre, who for two years had been very much disturbed by loss of sleep in addition to the usual nervous symptoms accompanying her disease. On December 16th, she took thirty grains of sulphonal at 10 P.M., and slept without interruption until 8 o'clock the next morning, when she was awakened by her sister. On attempting to raise her head from the pillow, she was taken with such violent pain in the head that she was forced to lie down again immediately. The headache was accompanied by great nausea, which was relieved by vomiting about one hour after she awakened. After the vomiting the headache gradually passed away, but the patient felt great weakness and trembling of the legs throughout the day. A few days afterwards the drug was administered in a dose of twenty grains; the effects were the same, but in milder degree.—*Medical Press of Western New York*, May, 1889.

OBSERVATION 20.—Mairet has used sulphonal with excellent re-

sults, but he has seen disagreeable results follow its use for several consecutive days, viz., intoxication, unsteadiness, mental weakness, nausea, vomiting, etc., which compelled him to suspend the treatment after three or four days. After some experience, these disagreeable symptoms can be avoided by an appropriate alternation of administration and omission of the remedy.—*Gaz. Hebd. des Sci. Med. de Montpellier*, March 23, 1889.

OBSERVATION 21.—Dr. M. H. Farmer was called to attend Mrs. C., in confinement. She was a woman of vigorous constitution, never having been sick a single day in her life. The child was born before he reached the house. Having cared for the child and removed the after-birth, the patient appearing exceedingly nervous and irritable, he administered fifteen grains of sulphonal, and fifteen minutes later, went home. Twenty-five minutes after reaching home, he was hastily summoned by the patient's husband. He repaired to the house, and found her with a face as white as a sheet. Radial pulse not perceptible. Respiration, eight to the minute. She was bathed in a cold clammy sweat and gave every evidence of a dangerous collapse. He immediately examined her for hæmorrhage, but found none. She rallied in about an hour under the persistent use of stimulants and hot applications, and has since done very well.—*Weekly Medical Review*, July 20, 1889.

OBSERVATION 22.—Dr. Wm. Henry Gilbert reports three cases of sulphonalism which came under his observation and treatment. All three were middle-aged ladies of good social standing, who had been advised by their medical attendants to take about two grammes of sulphonal whenever they could not sleep. This had been going on for from three to five months, and the use of the drug had become a perfect mania; so much so that the absence of it caused symptoms similar to those experienced when overcoming the morphia habit. A feeling of intense dizziness, weakness of thought and memory, tottering gait, as under the influence of alcohol, inability of writing straight (unsteady characters and in an ascending line), loss of appetite and general weakness caused the patient to seek medical aid. The complexion of these formerly healthy women had become sallow-looking, and the eyes rather dim and expressionless. After several weeks' treatment, sulphonal could be dispensed with, and subsequently the patients were restored to their former good health.—*Lancet*, October 25, 1890.

OBSERVATION 23.—Dr. C. H. Shivers reports three cases (this and the two succeeding observations) of deleterious effects from sulphonal in the *Medical and Surgical Reporter*, June 8, 1889. Mr. G., æt. 49 years, has periodical attacks of dipsomania about once a month, after which he cannot sleep. For several years, morphia and bromide of potassium would quiet him pretty fairly. In December, 1888, he began taking from twenty to thirty and even forty-five grains of sulphonal, dissolved in hot water, at bed-time or an hour before. The drug invariably keeps him awake and comfortable

during the night, and sleep follows, as a rule, some time the next day. He says it intoxicates him.

OBSERVATION 24.—W. P., during convalescence, could not sleep day nor night. Twenty-grain doses of sulphonal were given an hour before bed-time. He did not sleep a wink, and was a little delirious.

OBSERVATION 25.—Miss W., æt. 23 years, on a visit east from Colorado, where she resides on account of a phthisical tendency. After living here from two to four weeks she has loss of appetite, rapid and feeble pulse, great debility, a little cough, and wonderful sleeplessness, but no fever. The evening of May 18th, she was given fifteen grains of sulphonal in very weak hot coffee, at 9 P.M., and repeated the dose at half past ten. She scratched all night, was slightly delirious, and did not sleep. The next night Dr. Shivers gave her 30 grains in hot water at 9 P.M. The same symptoms followed with nausea and vomiting and marked debility.

OBSERVATION 26.—In a contribution to the study of the action of sulphonal, based on physiological experiments, Dr. John Gordon gives the following summary of results:

1. It reduces the excitability of the reflex function of the spinal cord.

2. It diminishes peripheral sensation.

3. Clinical observations showed that large doses slowed respiration.

4. It did not affect the pulse rate.

5. It slowly tended to destroy the conductivity of the motor nerves, and subsequent washings with salt solutions tended to restore it.

6. Saturated solutions slowly diminished irritability of muscle, but subsequent washings with salt solution tended to restore the irritability.

7. Small doses, 5 to 10 grains, increased excretion of urea.

8. Large doses tended to diminish excretion of urea.

9. Under the influence of the drug, the excretion of phosphates was diminished.

10. It had no marked influence on the excretion of the fluid constituents of the urine.

11. In none of these experiments was any cutaneous eruption observed.

12. There was no perspiration or flushing markedly observed.

13. Its influence on temperature was negative.

14. It occasionally caused vomiting, but there was no marked loss of appetite.

15. Diarrhœa was noticed occasionally.

16. In good health a hypnotic effect was distinctly produced.

17. In cases of insomnia it was reliable.

18. The sleep which followed its administration was generally tranquil and refreshing.

19. Sometimes the patient woke with a feeling of confusion.

20. Inco-ordination of the upper extremities occurred occasionally.

21. Inco-ordination of the lower extremities occurred occasionally.

22. A feeling of depression occasionally supervened.

23. Giddiness was observed.—*British Medical Journal*, March 29, 1890.

OBSERVATION 27.—Within the past few weeks some deaths have been reported from the use of sulphonal. The patients exhibited symptoms of acute nephritis, and died in a few days. The doses in each instance amounted to one gramme per day. The urine on examination showed the red color characteristic of methæmoglobin. It is suspected that the sulphonal used was not pure.—Vienna correspondent of *The Lancet*, October 11, 1890.

OBSERVATION 28.—Mathes after an extended experience has found sulphonal a valuable hypnotic, but he has noted after effects in the majority of instances, consisting of a feeling of fatigue and depression, ringing in the ears, headache, and sometimes vertigo. It was noted that these disagreeable after-effects were more marked when the sleep produced by sulphonal had been accidentally disturbed. If the patients were allowed to sleep uninterruptedly for some time, distressing effects did not usually appear.—*Wien. Med. Blatter*, December 13, 1888; quoted by *Therapeutic Gazette*, February, 1889.

OBSERVATION 29.—Ott has met with cases where sulphonal has produced nausea and vomiting. It cannot be looked upon as an invariable hypnotic.—*Prag. Med. Wochenschr.*; quoted by *Therapeutic Gazette*, February, 1889.

OBSERVATION 30.—Lovegrove says the effects of sulphonal on patients are very discouraging. For several hours after taking the drug, no appreciable effect could be observed, but during the greater part of the following day, there was extreme drowsiness, also considerable cyanosis.—*British Medical Journal*, May 26, 1888.

OBSERVATION 31.—This and the next succeeding ten observations are from Dr. J. P. Crozier Griffith. George H., suffering from rheumatoid arthritis and nervous insomnia. Fifteen grains of sulphonal were without hypnotic action, and twenty-five grains had but little more effect. After these smaller doses there were short bewildered troubled periods of sleep throughout the night, with a tendency to talk at random; and upon the days following the patient was drowsy and uncomfortable.—*Therapeutic Gazette*, May 15, 1889.

OBSERVATION 32.—Miss O.; hysteria; great nervousness and insomnia. Sulphonal in a dose of thirty grains given on three successive evenings was only productive of short delirious dozes, and upon the morning following there were nausea, headache, and generally unpleasant sensations.—*Ibid.*

OBSERVATION 33.—Lizzie H.; insomnia. Forty grains of sulphonal were taken on retiring on four consecutive nights. On the first three a rather restless slumber, in which the patient talked somewhat, began in one and a half to two hours; followed at about

3 to 4 A.M., by a deep sleep lasting until 8 or 9 in the morning when she felt refreshed. On the fourth night instead of awaking refreshed passing into the deep quiet sleep at 3 o'clock, she arose still unconscious, walked about the room with a candle in her hand and screamed at the top of her voice. As she had never been known to act in this way before, her relatives were not without reason in considering the medicine at fault.—*Ibid.*

OBSERVATION 34.—Mrs. McC.; disseminated sclerosis; extreme and persistent insomnia. Small amounts of sulphonal had no effect whatever. Finally sixty grains were given on each of four successive nights, but the patient only appeared to become more excited and nervous, and more wakeful, if possible.—*Ibid.*

OBSERVATION 35.—Jennie S., neurasthenia; anæmia; annoying insomnia. Forty grains of sulphonal given on two successive nights made her very excited and semi-delirious without producing any desire for sleep until 4 A.M. From this time until the evenings of the days following, she experienced nausea, headache, and vertigo.—*Ibid.*

OBSERVATION 36.—Mrs. E.; rheumatoid arthritis; simple insomnia. Thirty-five grains of sulphonal had a very exciting effect through the whole night, producing short dreamy snatches of sleep. On the next day there was nausea and drowsiness.—*Ibid.*

OBSERVATION 37.—Twenty grains of sulphonal excited Mrs. B. through the whole night without producing any sleep whatever.—*Ibid.*

OBSERVATION 38.—James B.; alcoholic delirium of a mild type. Patient was restless, but never violent, often wanting to get out of bed, but easily restrained. He was sleeping quietly at 4 A.M. when forty grains of sulphonal were given as a test, and in about half an hour he became unruly and delirious. He had not acted so badly before or afterwards until the like amount was administered on two other occasions, when the same results were experienced.—*Ibid.*

OBSERVATION 39.—Mr. H.; mitral regurgitation; insomnia. Forty grains of sulphonal administered on each of several nights produced for some hours, intense drowsiness and the desire to go to sleep without the power to do so. The patient walked the floor and felt "trembling" and nervous, and queried afterwards if the powders could have made him so "light headed."—*Ibid.*

OBSERVATION 40.—James M.; aortic regurgitation; insomnia. Forty grains of sulphonal produced sleep lasting most of the night; but on the next day the patient suffered from swimming of the head, and oscillated while walking.—*Ibid.*

OBSERVATION 41.—Mr. C.; plethora; greatly troubled by insomnia. After forty grains given in the evening, the patient slept well, but could with difficulty arouse himself in the morning, and felt all day as stumbling over something.—*Ibid.*

OBSERVATION 42.—Dr. C. W. Hogarth observed in three cases in which sulphonal had been administered a dilatation of the pupil with marked sluggishness about its reaction to light and accommo-

dation. Control experiments proved that this effect was due to the drug.—*Lancet*, October 12, 1889.

Dr. R. Percy Smith reports five cases in which temporary loss of power in the lower extremities occurred after sulphonal had been administered. They are as follows:

OBSERVATION 43.—M. B., suffering from acute mania with great violence and destructive and dirty habits of eight months' duration. Sulphonal was given in thirty-grain doses every night for eight days, but was discontinued because the patient seemed to be unable to stand, and spent the day lying about on the couches or on the floor. The symptoms passed off in twenty-four hours after the drug was discontinued.—*The Lancet*, 1889, p. —.

OBSERVATION 44.—M. J. S., æt. 39 years, acute mania, with great excitement, sleeplessness and destructiveness. Sulphonal given every night in thirty-grain doses. After fifteen days she was in a drowsy stupid condition, almost as if half-drunk, unable to stand or walk properly. The knee-jerks were present and normal. Sulphonal was discontinued, but resumed later, and it again produced apparently a loss of motor power in the legs, as the patient rolled about when set on her feet, and apparently preferred lying on the floor. On recovery the patient appeared to have a clear memory of the attack, and stated that she had not suffered from giddiness, but that she felt powerless to stand and use her lower extremities effectively.—*Ibid.*

OBSERVATION 45.—M. M., æt. 29 years, third attack of insanity following the birth of twins; acute mania, with obscenity, destructiveness, and sleeplessness. Sulphonal given in repeated doses until patient had appearance of being drunk, tumbling about and walking unsteadily.—*Ibid.*

OBSERVATION 46.—E. L. G., æt. 50 years, recurrent mania with intervals of health. Repeated administration of sulphonal was followed by a feeling of giddiness, inability to walk with any ease, her legs seeming to be too heavy; the difficulty in walking seemed to be greater than could be accounted for by the vertigo.—*Ibid.*

OBSERVATION 48.—M. A. M., æt. 50, after three doses of sulphonal became quite confused, walked with her eyes shut, though not asleep, did not know where she was, had to be washed and dressed, and could walk only with assistance.—*Ibid.*

Dr. Smith is strongly of the opinion that the difficulty in locomotion is due to disorder of the cortical functions of the cerebrum and not to the vertigo.

OBSERVATION 49.—Mairet (*Deutsche Med. Wochenschrift*, October 3, 1889), observed in one case a sudden violent congestion of the lungs, a fact confirmed by the experimental observation that the

lungs and other viscera are in a state of violent congestion after poisoning with sulphonal.—*Therapeutic Gaz.*, January, 1890.

OBSERVATION 50.—Jastrowitz reports muscular weakness, disturbance of sight, ringing in the ears, and collapse from the use of sulphonal.—*Therapeutic Gaz.*, January, 1890, p. 31.

OBSERVATION 51.—Umpfenbach (*Therapeutische Monatshefte*, 2, 1890), reports the case of a woman who took thirty grains of sulphonal, which did not bring sleep, but produced violent palpitation of the heart the following day.—*Therapeutic Gaz.*, 1889, p. 315.

OBSERVATION 52.—Umpfenbach (*Therapeutische Monatshefte*), also reports the case of a paranoiac patient to whom thirty grains were given. On the following morning there was slight chill with coldness of the hands and face, trembling of the extremities and a small feeble pulse.—*Ibid.*

OBSERVATION 53.—Umpfenbach also calls attention to two cases of paralysis in which sulphonal caused an immediate increase of the paralytic symptoms.—*Ibid.*

OBSERVATION 54.—Popoffet and Poanovsky have made elaborate experiments on the lower animals, and have summarized their investigation concerning the action of sulphonal as follows:

1. Sulphonal diminishes the excitability of the cerebral cortex and of the spinal cord.

2. In small and moderate doses sulphonal increases blood-pressure through excitation of the vaso-motor centre and depression of the pneumogastric. In large doses it diminishes blood-pressure through paralysis of the muscular tissue and ganglionic centres of the heart.

3. The acceleration of the pulse is due in part to the stimulation of the accelerator nerves of the heart, but especially to the depression of the pneumogastrics.

4. Sulphonal in small moderate doses does not modify the constitution of the blood, but in large doses it produces destruction of the red-blood corpuscles.

5. Sulphonal increases the reduction of oxyhæmoglobin in the blood, possibly by reducing the intimacy of union of oxygen and hæmoglobin.—*Therapeutic Gaz.*, 1889, p. 516.

OBSERVATION 55.—Knaggs reports a fatal case where a very large quantity of sulphonal had been taken. It produced complete stupor, insensibility, and anæsthesia; pupils remained normal and reacted to light. Conjunctiva insensible to the touch. Finally anæsthesia so profound as to prevent swallowing. Temperature ranged from 100° to 103°; body bathed in a profuse perspiration; total suppression of urine.—*British Medical Journal*, 1890, ii., p. 955.

OBSERVATION 56.—Mathes observed after-effects in the majority of instances after using sulphonal. These consisted of a feeling of fatigue and depression, ringing in the ears, headache, and sometimes vertigo. Disagreeable effects were most marked when sleep was disturbed; not observed when the patient was allowed to rest uninterrupted.—*Therapeutic Gaz.*, 1889, p. 31.

OBSERVATION 57.—Raymond, from a large number of observa-

tions, concludes that sulphonal is far from an ideal narcotic. It had scarcely any action on the respiratory system; on the circulatory system it had the same influence as sleep when this was natural; the temperature was slightly lowered. The secretion of urine was increased, that of the sweat-glands diminished. The tongue and mouth were sometimes dry; occasionally, though rarely, the patient vomited. It sometimes had a hyperæsthetic action. The disadvantages attending the use of sulphonal were fatigue, giddiness, and sometimes positive vertigo.—*Journal of the American Medical Association*, xiii., p. 713.

OBSERVATION 58.—Dr. W. H. Flint, while well pleased with the action of sulphonal as a hypnotic, has observed mild toxic symptoms as fatigue, depression, tinnitus and nausea. He has also noted marked pallor of the face, and œdema beneath the eyelids, in several cases on awaking from sleep. Graver symptoms thus far reported were diarrhœa, peripheral aphasia, ptosis, rubeola, urticaria, brachycardia (does he mean tachycardia or bradycardia?) inco-ordination, semi-coma and collapse.—*New York Medical Journal*, 1, 498.

OBSERVATION 59.—Dr. S. G. Burnett has tried sulphonal on himself and 16 patients. On himself sleep was followed by dizziness, which passed away on rising, but suffered from muscular weakness. Volition was unaffected, though co-ordinating powers were defective. In a small number of cases it disorders the digestive apparatus, causing emesis, thirst, anorexia, etc.—*New York Medical Journal*, xlix., p. 238.

OBSERVATION 60.—Rottenberg reports the case of a man, æt. 54, suffering from sleeplessness. He took, in the course of a week, between two hundred and seventy and three hundred grains of sulphonal. Then came on loss of appetite, anxiety, vertigo and clonic spasms of the muscles, especially of the trunk. The patient had the appearance of a dement, was restless, sleepless, excited, was unable to add, and his memory of the date was faulty. He felt unhappy. His replies to questions were inexact and confused. During the examination he had repeated attacks of clonic spasms with dyspnœa and feeling of extreme anxiety. Cessation of the use of the drug restored his natural joyousness, the spasms stopped, and anxiety and vertigo disappeared.—*North American Journal of Homœopathy*, March, 1892; quoted from *Therap. Monatshefte*, December, 1891.

OBSERVATION 61.—Francisco says that sulphonal, given in doses of three grammes, exerts an influence upon the heart and bloodvessels, reinforcing the systole and increasing the vascular tone. This action upon the bloodvessels is not continuous, for after a certain time there is a dilatation and a progressive loss of elasticity, beginning first in the vessels of the brain, then extending to the periphery.—*Journal of Nervous and Mental Diseases*, March, 1892.

OBSERVATION 62.—Dr. Bresslauer, in making a thorough investigation with sulphonal in the treatment of neuroses says, that while in some cases it has been known to do good, yet the bad effects of the drug are so apt to come on and prove fatal when least expected

that he does not advise its use unless cautiously administered. When any one symptom came on which could be attributed to the remedy, it should at once be left off; even then it was too late in most cases to save the patients from heart-failure, to which, as a rule, they succumb. The symptoms caused by the toxic action of the drug were first constipation, then obstipation, following this dark-colored urine, thirst, increased pulse, appearance on the legs of bluish spots, similar to purpura, ataxia and numbness, a difference in the temperature of the upper and lower parts of the body, and finally heart-failure.—*Neurologisches Centralblatt*, quoted by *Journal of Nervous and Mental Diseases*, August, 1891.

OBSERVATION 63.—Neisser reports the case of a fifteen-year-old apprentice, in a drug-house, who took 100 grammes of sulphonal. He was profoundly unconscious, temperature, 96° ; respiration, easy and quiet; pulse, 100, rather small, but regular. On the following morning the patient was quietly sleeping, the countenance slightly reddened, the mouth closed, respiration quiet (18) and deep, pulse 96, and extremely variable, reflexes uncertain, except that the corneal reflex was always distinct. The pupils of medium dilatation reacted variably to light, returning immediately to their former size. The patient did not react to cries and shaking. Pricking of the hands and feet produced no effect except a distinct widening of the pupil. Now and then languid jactitation occurred. There was neither albumen nor sugar in the urine. Sulphonal was detected in that excretion unchanged. The temperature rose to 101.3 degrees on the fourth day; fell to normal on the next day; rose to 100.8 degrees two days later, and then fell to normal, where it remained. There was nothing pathological on the part of the lungs.

On the fifth day the patient opened his eyes repeatedly, but was completely unconscious. The pupils were wide and reacted sluggishly. After a time languid answers came to repeated questioning. On the sixth day he answered questions slowly, and took nourishment by the mouth. He imagined he was on a ship (dizziness?) In the course of the day he could see everything. Ocular field normal. He could not walk or stand without assistance.

On the palmar surface of both wrists there was an itching exanthema of numerous small, pale-red papillæ as large as the head of a pin.

OBSERVATION 64.—Dr. O. Hammersteen has observed four cases where darkish brown-red urine was passed by insane female patients. The urine was examined and found to contain hæmatoporphyrin, or some analogous substance, as well as other abnormal coloring matters, which, like hæmatoporphyrin, denote an alteration in the relation of the coloring matter of the blood. All these cases had been treated with sulphonal, but it was difficult to decide what relation the drug bore to the symptom, inasmuch as it was sometimes present when they were not taking the drug.

A Danish physician observed a dark, blackish-red color of the urine in nine cases of poisoning by sulphonal. In two cases he remarked albuminuria and a few hyaline cylinders.

Dr. A. Jolles examined the urine of four women which presented the reddish-brown discoloration of hæmatoporphyrinuria, after using sulphonal, two grains per diem. He comes to the following conclusions: 1. The peculiar reddish-brown color of the urine, after poisoning by sulphonal, is due to the presence of hæmatoporphyrin. . . . 5. After poisoning by sulphonal, distinct renal cylinders as well as the presence of albumen are to be demonstrated.

Professor Salkowski reports the results of his examination of specimens of urine coming from three women who had taken sulphonal, and where hæmatoporphyrinuria was noticed. Compiled from various sources, by Dr. Frank H. Pritchard, and published in *Review of Insanity and Nervous Diseases*, March, 1892.

OBSERVATION 65.—Kober (*Centralblatt, f. Klin. Med.*, March 12, 1892) relates the following case: A man, aged 52, became very melancholic in consequence of increasing deafness, and more particularly of tinnitus. The sleeplessness was treated by bromide, salts, and sulphonal. The latter was given in doses of 0.5 to 1.5 grammes (the large dose rarely), and continued during four or five weeks. After a temporary improvement, repeated vomiting, abdominal pain referred to the navel, and obstinate constipation, supervened. A change in the urine was also noticed; the daily quantity was under one litre. It was burgundy-red to reddish-black in color, and contained at first no albumen and never any sugar. It did not give exactly the tests for hæmoglobin. Heller's reaction was absent. The specific gravity was 1021. The coloring matter was partly thrown down by alcohol. The crystals thus obtained were soluble in water, not in ether or chloroform. The chloride salt was taken up by amyl-alcohol with a red coloration. Lead oxide precipitated and took up the coloring-matter; when treated with acetic acid and common salt, hæmin crystals were obtained. No sulphonal was present. The sulphonal was omitted, but the color of the urine deepened, albumen and formed elements, leucocytes, casts, but no red cells being found. Then retention of urine supervened, and later death. It would appear that the sulphonal was stored away somewhere in the body, possibly in the liver. The absence of albumen at first, would apparently prove that the excretion of hæmoglobin could produce a true renal inflammation.—*Supplement to the British Medical Journal*, April 2, 1892.

OBSERVATION 66.—Dr. S. G. Burnett reports a case in which sulphonal was given in large doses in mistake for salol, to a patient suffering from dysenteric diarrhoea. The patient went into a deep sleep, the countenance presented a peculiar blanched, cyanotic appearance. The pulse was 55, full and bounding, but not strong; respiration, 14; temperature 98° F. The latter had been 102° F. before administering the sulphonal. The author observes that all his cases of sulphonal poisoning were attended by lowering of the temperature. The next day the patient experienced a pleasant stupidity, declined food, and possessed no control over co-ordination, and after one or two efforts could not be induced to try to walk.

Examination of the knee reflex was negative, excepting when the patient was caused to divert her mind to something else, and then only a very slight reflex was present. Some ten days were required for her to regain her co-ordinating powers, at the end of which time the knee reflex was found to be normal.—*New York Medical Journal*, April 9, 1892.

OBSERVATION 67.—A man aged 69 years suffered from recurrent mania. The deep reflexes were exaggerated. Sulphonal was given for several nights when he developed inco-ordination until he walked with uncertainty, and would fall if not very careful. His reflexes were examined and found to be present.—*Ibid.*

OBSERVATION 68.—A case of profound insomnia with exaggerated reflexes. After the patient had taken twenty-five grains of sulphonal for four successive evenings, inco-ordination appeared with reduction of the excessive reflex considerably below normal.—*Ibid.*

MIND.

Extreme mental restlessness 2^a.

Restlessness, 60.

Agitation, 2^a.

Confusion, 2^a, 7.

Feeling of depression, 26, 28.

Anxiety, 2^a, 60.

With open eyes, illusions and hallucinations of a sad character, 2^a.

Talked wildly, had tremors, finally becoming so ugly as to compel restraint, 7.

Excitement increasing to delirium with delusions, 8.

Delirium, 24, 25, 26, 32.

Lethargy, 8.

Mental depression, 8.

Apathy and listlessness, 13.

Answers questions only after marked and painful delay, as if comprehension was labored and unnaturally slow, 13.

Indifferent to persons and things that had formerly interested him, 13.

Made mistakes in his books which it took him a long time to discover; computation of sums, which had formerly been mere play, became laborious, 13.

Unable to add, 60.

Naturally punctual in his habits, he forgot his engagements, 13.

Memory and judging powers became sensibly impaired, 13.

Melancholiacs complained of hallucinations after its administration; hypochondriacs are depressed, 15.

Delirium, heard persons talking to her, 14.

Holds imaginary conversations with absent friends and strangers, 14.

Complains of having two heads, two pairs of arms, and double vision, 18.

Mental weakness, 20.

Weakness of thought and memory, 22.

Random talk during sleep, 21, 31.

Excitement, 8, 34, 35, 36, 37.

Excitement, with semi-delirium, 35.

Unruly and delirious, 38.

Became confused and walked with eyes shut, though not asleep, 48.

Stupor from which he could be aroused, but was somewhat incoherent, and promptly lapsed into stupor; cyanosis and some stupor, 7.

Patient had the appearance of a dement, 60.

Memory of the date faulty, 60.

Unhappy, 60.

Replies to questions inexact and confused, 60.

SENSORIUM.

With eyes closed, sensation as if the bed swayed, 2^b.

Patient stupid, appears as if paralyzed, 2^a.

Sensation as if the bed moved, 2^a, 2^c.

Vertigo, 1, 2^b, 2^c, 6, 7, 8, 9, 15, 17, 20, 22, 26, 28, 35, 40, 46, 58, 59, 60, 63.

Felt that she must walk with one leg over the other, 2^c.

Vertigo; unable to rise; can walk only with assistance, 6.

Stupor, following delirium, 7.

Stertor with cyanosis, 7.

Semi-stuporous condition with stertorous breathing, 7, 12.

Stupor, 2^b, 2^c, 15.

Drowsy and stupid as if half-drunk.

HEAD.

Headache, 1, 4, 8, 9, 19, 28, 32, 35.

Frontal headache, 8, 9.

Headache on attempting to raise her head from the pillow, accompanied by great nausea, which was relieved by vomiting about one hour after she awakened, 19.

Hanging of the head from extreme fatigue, 4.

EYES.

- Double vision, 2^a.
- Eyelids could not be raised, 2^a.
- Ptosis, 12, 58.
- Pupils normal, 12.
- Pupils contracted, 2^a, 18.
- Eyes dim and expressionless, 22.
- Dilatation of the pupil with marked sluggishness in its reaction, 42, 63.
- Disturbance of sight, 50.
- Eyes without expression, pupils contracted, 2^a.
- Heavy look about the eyes, 5^a.

EARS.

- Deafness, 1.
- Tinnitus, 28, 50, 58.

FACE.

- Sallow, 2^a.
- Heavy sotted look suggestive of imbecility, 11.
- Face drawn slightly to the right side, 12.
- White as a sheet from collapse, 21.
- Pallor of the face and œdema of the eyelids on awaking from sleep.

TONGUE.

- Speech hardly audible, the tongue being as if paralyzed by an apoplectic attack, 2^a.
- Difficult motion of the tongue, 4.
- Ataxic movement of the tongue, patient's speech, becoming thick and stammering, 5^b, 5^c.
- Articulation poor and feeble, distinguished with difficulty, 12.
- Stammering speech, 5^a.
- Tongue when protruded deviated to the right.
- Aphasia, 58.

MOUTH.

- Bitter taste, 4.
- Mouth parched and tongue dry, 12, 57.

DESIRES ; AVERSIONS.

- Loss of appetite, 2^a, 2^b, 4, 22, 59, 60.
- Thirst, 59.

NAUSEA AND VOMITING.

Nausea, 1, 2^b, 7, 20, 23, 25, 29, 32, 35, 36, 59.

Nausea on any effort to rise, 1.

Vomiting of food; stomach refusing for many hours to retain any food, 6.

Vomiting, 2^b, 6, 15, 17, 20, 23, 25, 26, 29, 35, 59.

ABDOMEN.

Abdominal pain referred to the navel, 65.

STOOL.

Constipation, 2^a, 12, 62, 65.

Constipation with tenesmus, 12.

Paralysis of the sphincter ani shown by inability to retain the enema, 12.

Diarrhœa, 15, 17, 26.

URINE.

Ischuria, 2^a.

Constant desire to urinate, but passed only a teaspoonful at a time, urine normal, 12.

Diuresis, 17.

Small doses increase excretion of urea; large doses diminish, 26.

Excretion of phosphates diminished, 26.

No influence on fluid constituents of the urine, 26.

Death from nephritis, 27.

Urine contained methæmaglobin, 27, 54.

Suppression of urine, 54, 57.

Urine increased, 57.

Dark colored urine, 62, 65.

Urine, dark brownish red, containing hæmatoporphyrin, 64.

Albuminuria with hyaline cylinders, 64.

Albuminuria with leucocytes and casts, 65.

SEXUAL ORGANS.

Annoying priapism, 8.

BREATHING.

Death from failure of respiration, 16.

Respirations eight to the minute, 21.

Large doses slowed respiration, 26.

Stertorous breathing, 12.

LUNGS.

Violent congestion of the lungs, 49. (Confirmed by experimental observations.)

HEART AND PULSE.

Pulse, 50, 2.

Pulse, 55; after stimulation rose to 70.

Radial pulse almost imperceptible, 12, 21.

Cyanosis, 30.

Violent palpitation, 51.

Small, feeble pulse, 52.

Pulse, 100; small but irregular, 63.

Increased blood-pressure through excitation of the vaso-motor centre and depression of the pneumogastric, 54.

In large doses it diminished blood-pressure by paralysis of the muscular tissues and ganglionic centres of the heart. Acceleration of the pulse is due, in part, to stimulation of the accelerator nerves of the heart, but especially to depression of the pneumogastric, 54.

Pulse, 100, and weak, 2^a.

In doses of 3 grammes reinforces the systole and increases vascular tone. This action upon the bloodvessels is not continuous, for after a certain time there is a dilatation and a progressive loss of elasticity, beginning first in the brain, then extending to the periphery, 61.

Heart-failure, 62.

UPPER EXTREMITIES.

Motion of the hands impossible, 2^a.

Ataxic movements of the hands, 12.

Attempting to take hold of an object, he would miss it, 18.

Inability of writing straight, 22.

Inco-ordination of upper extremities, 5^b, 26.

Erratic gesticulation, 5^a.

LOWER EXTREMITIES.

Ataxic movements of the limbs, 5^b, 62.

Gait staggering, 5^a, 9, 18.

All movements jerky and uncertain, 5.

Extremities cold, 12.

Great weakness and trembling of the legs, 19.

Tottering gait, as under the influence of alcohol, 22.

Inco-ordination of lower extremities, 26, 41.

Oscillation while walking, 40.

Unable to stand; spent the day lying about on the floor, 43.

Inability to walk with ease, her legs seeming to be too heavy, 46.

(Vertigo was present, but not sufficient to cause the difficulty in walking.)

Could not walk or stand without assistance, 63.

Knee-jerks diminished or absent, 66, 67, 68.

NERVES.

Extreme bodily restlessness, 1, 2^a, 5^a.

Great hyperæsthesia, 2.

Muscular inco-ordination, 8, 12.

Writhing, grimacing, as in chorea, 10.

Tremor, 7.

Reduces excitability of the reflex functions of the spinal cord, 26.

Diminishes peripheral sensation, 26.

Nervous, 34.

Trembling and nervousness, 37.

Patient walked the floor, 39.

Trembling of the extremities, 52.

In two cases caused increase of paralytic symptoms, 53.

Diminishes excitability of the cerebral cortex and spinal cord, 54.

Muscular twitchings, 2^a.

Acted like a drunken man, 18.

Clonic spasms of the muscles, especially those of the trunk, 60.

Numbness, 62.

SLEEP.

Great inclination to sleep, 4.

Sound sleep for several hours, waking refreshed. (General observations.)

Great restlessness, 6.

Fidgety, wakeful night, 7.

Wakefulness, 23, 24, 34.

Drowsiness, 30, 36.

Bewildered, troubled sleep, with tendency to talk at random, 31.

Rose in her sleep and walked about the room, and screamed at the top of her voice, 32.

Desires to go to sleep without the power of doing so, 39.

CHILL; FEVER; SWEAT.

Body hot, 4.

Chilliness, 15.

Cold clammy sweat, 21.

Chill, 52.

Coldness of the hands and face, 52.

Temperature, 96° ; rose to 101.3° on the fourth day, 63.

Temperature, 100° to 103° .

Difference in temperature of upper and lower parts of the body, 63.

SENSATIONS.

Peculiar disturbance of sensation causing her to assert that she has four legs, 2^a.

Sensations of heat and cold, 1, 2^a.

Feeling of extreme fatigue, manifested by great inclination to sleep, 4.

General unpleasant feeling, 7, 32.

General tired feeling, 2^c, 4.

TISSUES.

Muscular contractions, 2.

Muscular irritability diminished, 26.

In large or small doses does not alter the constitution of the blood; but in large doses does produce destruction of the blood corpuscles, 54.

Increases the reduction of the oxyhæmoglobin in the blood, possibly by reducing the intimacy of union of oxygen and hæmoglobin, 54.

SKIN.

Cool, 1.

Moderate itching followed by the appearance of a scarlet exanthem upon the outer side of each mamma. The exanthem was distinctly limited from the unaffected skin. By the next night the exanthem had extended to the inner side of each arm, and also towards the sternum, 3.

Following a number of gastric symptoms an exanthem made its appearance beginning on the head, and gradually extending over the entire body, resembling in form and color the eruption of measles. The lesions were bright-red macules the size of lentils. These in many places formed large macules by their coalescence, and at their

centre presented a papule which had its origin in a follicle. The body was hot; the skin had a burning sensation. The mucous membranes were not affected. With the appearance of the exanthem, the other symptoms disappeared, 4.

Erythematous eruption all over her thighs, the skin becoming everywhere of a deep red tint, without papules or other changes, 11.

Scratched all night, 25.

Bluish purpura like spots on the legs, 62.

Itching exanthem of numerous pale-red papillæ on the palmar surface of both wrists, 63.

STAGES AND STATES.

General wretched feeling, 7.

General weakness, 22, 25.

Collapse, 21.

AGGRAVATIONS AND AMELIORATIONS.

Headache worse on attempting to rise.

Ataxia worse from alcoholic stimulants, 5.

REMARKS.

From the above it can readily be seen that sulphonal exerts a most remarkable action upon the brain. Not only is it capable of acting as a hypnotic of no mean power, but it also produces quite a variety of mental symptoms. These symptoms range all the way from a simple depression to a wild delirium. Personal peculiarities of the subject of the observation doubtless plays an important part in this result. The practical application of these mental symptoms will be found, it seems to me, in the treatment of insanities unattended by organic changes in the brain. If the great variety in the character of the mental symptoms of the drug is to be any guide, we will find in sulphonal a remedy having great opportunities in the treatment of insanities.

Among acute diseases, sulphonal should be applicable in the treatment of typhoid types of disease. Not only may it prove useful in typhoid fevers, but also in pneumonia, scarlatina, and measles when these diseases assume a low type.

The head, eye, ear, and tongue symptoms are not sufficiently characteristic to lead to any special therapeutic suggestions based on them. It is evident, however, that they are all dependent upon the

action of sulphonal on the brain, and are confirmatory of the suggestions already thrown out, that the drug has an important field for it in the treatment of cerebral troubles.

Concerning these symptoms, future investigation will doubtless show them to be far more frequent than the above observations indicate. In very few instances probably was any systematic examinations of the organs of special sense made. So that only when the symptoms were of such a character as to force themselves upon the observer, were they noticed.

The gastro-enteric symptoms are the result of perverted peristalsis. They do not indicate any special involvement of the digestive functions *per se*. They suggest the use of sulphonal in neurotic dyspepsia and diarrhœas.

The action on the urinary organs is decidedly interesting. Taking the skin symptoms also into consideration, one is at once led to think of sulphonal as a possible remedy in post-scarlatinal nephritis. It certainly seems to be better suited to the totality of such cases than is either cantharis or terebinthina, the remedies we are accustomed to using most frequently in that disease.

In pneumonias of a low type, it should also be thought of.

The heart symptoms of the drug are not such as to lead to its use in heart disease *per se*; but when the heart is affected secondarily to kidney disease or as a result of neurotic trouble, or when the cardiac symptoms above mentioned occur during the course of acute or chronic diseases, then sulphonal should be thought of.

The lack of co-ordination has led to the suggestion that sulphonal be used in ataxia. This I think is a mistake; for the sulphonal ataxia is dependent upon cerebral disorder entirely. I think the proper sphere of the drug is limited entirely to cases of cerebral neurasthenia; and that it will be found to do little good in organic diseases of the spine. This view is further confirmed on reading the nervous symptoms.

In closing there are two points upon which I wish to lay stress. The first is that the array of symptoms in the schema above given is such that a study of them alone gives an inadequate idea of the symptomatology of sulphonal. Stated in this way, it is decidedly disconnected; and one finds the greatest difficulty in making a mental picture of the drug. The mere verbiage of a symptom is of but little value, for it is largely dependent upon the personality of the reporter or the prover, and yet it is words that make the schema; they are made subservient to idea. What will be expressed in one way by

one man, will be stated in very different language by another. Symptoms are thus multiplied indefinitely to the detriment of scientific accuracy. Better by far, will it be to make the schematic arrangement of symptoms secondary to a thorough understanding of the physiological action of the drug on the different organs.

The second point on which I wish to lay stress is: This paper is designed to introduce sulphonal as a homœopathic remedy. It will have failed of its purpose if my readers should begin to use it indiscriminately as such, without regard to indications, and in conditions for which it is not suited. Such a course savors of old-school methods, and is to be mentioned but to be condemned.

Since writing the above I have received the following report of cases gleaned from foreign sources by Dr. Frank H. Pritchard, of Norwalk, Ohio:

DR. CHRISTIAN GEILL.—*Sulfonal og Sulfonalforgiftning Hospitals Tidende*, Nos. 31, 32, 1891, Danish.—The writer presents the following picture as characteristic of sulphonal poisoning: Locomotion becomes difficult, beginning with ataxia and passing on to complete paresis; it first appears in the lower extremities and goes upwards. The patient, as a rule, is sleepy and exhausted, with confusion of the sensorium. He falls and tumbles about as if intoxicated, and trying to lean up against everything. The movements of the arms become uncertain, fumbling and ataxic. The legs gradually become completely paralyzed, the arms less rarely being so severely influenced. Paresis of tongue and pharynx are added to the picture, as is seen by the dysphagia and the difficult, indistinct, and almost inaudible speech; finally disappearance of the tendon-reflexes, anæsthesia of the skin and conjunctiva. At the same time there develops, as a rule, disturbances of the digestive tract, constipation, lack of appetite, nausea, vomiting and diarrhœa. Less frequently there appear disturbances of respiration and circulation, with weak pulse. Finally there is said to be caused abnormal sensations and oversensitiveness of the sensorium, excitement, anxiety and hallucinations, mostly of a terrifying nature, delirium and stupor, which may even pass on to coma. Dose necessary to produce a poisoning varies greatly in different cases. Fischer relates the case of a morphinist, who, after receiving for two successive evenings, developed very grave symptoms from 1 gramme each evening.

Levzinski also saw a morbilliform eruption after sulphonal.—*Upsala Lakerefererings Færhandlinger*, xxiv., p. 319, 1889.

Pneumonia as a Complication.—Some writers have mentioned pneumonia as a result of sulphonal. Marandon de Montiel, cited by Christian Geill, saw a case of pneumonia, double-sided, which was apparently due to sulphonal. The drug causes hyperæmia of the lungs in animals. Umpfenbach (*Therapeutische Monatshefte*, H. 2,

p. 66, 1890) saw a case of croupous pneumonia in a 41-year-old woman who was suffering from sulphonal-poisoning, with universal paralysis. The paralysis was right-sided. The case ended fatally. The post-mortem revealed nothing beyond hyperæmia of the spinal cord, which could be ascribed to sulphonal.

Cases of Poisoning by Sulphonal Observed in the Aarhus Asylum, Aarhus, Denmark.—1. Forty-four year-old male, insane, very restless at night; December 12, 1890, 2 grammes sulphonal in evening. Completely quiet at night; last night. Sits and sleeps the whole day. No sulphonal given till January 1, 1891; 1 gramme sulphonal; January 4, 1891, greatly collapsed and exhausted; can scarcely stand on his legs; urine of normal color; sulphonal discontinued; symptoms soon disappeared. Took in all 9 grammes in five days.

2. Thirty-four-year-old male, periodic mania; received during an attack of violent restlessness, excitement, constant motion and filth, sulphonal 5 grammes *bis die* and 1 gramme in evening. Two days after, quieter but still noisy and restless. Still, seven days after, completely quiet; two days after this, undoubted symptoms of poisoning; sleeps whole day and night; awakened with difficulty; yet cannot stand upon his legs. Sulphonal left off. Symptoms disappeared rapidly; 22 grammes received in all in eleven consecutive days.

3. Woman, 19 years old, recent mania, violent and filthy; sulphonal 5 grammes twice a day, and 1 gramme in the evening. Sleeps quietly; restless at night still. Five days after, sleepy; cannot stand upon her legs; staggers; sulphonal discontinued. Slept the entire next day; at night, restless; symptoms soon disappeared; urine normal. 10 grammes in five consecutive days.

Cases with Digestive Disturbances.—4. Woman, 31 years old, acute hallucinatory excitement; very restless and unmanageable. Sulphonal 2 grammes in evening, July 15, 1890. Slept the entire night. July 23d, quiet day and night. Somewhat uncertain in her movements in walking; sulphonal left off; thunders upon the door; filthy. July, quieter. August 8th, terrifically violent; 2 grammes in evening. August 27th, quieter; sleeps at night; sulphonal left off. August 30th, violent; sulphonal 2 grammes in evening. September 1st, quiet; sulphonal left off. September 5th, 16th, 20th, quiet. September 16th, 2 grammes sulphonal. October 1st, violent; sulphonal 2 grammes. October 6th, quiet of nights; sleeps all day; is weak and staggering; eats nothing; bends double and has pains in the abdomen; sulphonal discontinued. October 10th, apparently well; eats, and is quiet; urine all the time normal in color; 56 grammes sulphonal in sixteen weeks.

5. Woman, 21 years old, melancholia; anxious and restless; lies on the floor all night. June 30th, 1890, sulphonal 2 grammes in evening. July 1st, slept whole night. July 19th, quiet of nights, but sleepy and dosing during the day, and is uncertain in her gait; sulphonal left off. July 26th, restless and filthy; sulphonal 1 gramme in evening. July 31st, still somewhat restless; sulphonal

2 grammes. August 11th, quiet up to now. August 13th, vomits frequently night and day; is somnolent, and sleeps between the vomiting attacks. To-day, is staggering, and acts like a drunken man. Pulse 100, small and irregular. Hands cool, clammy and apparently without strength. Pupils moderately well dilated. Urine dark, of a port-wine color; acid, no albumin; sulphonal left off. Symptoms disappeared in a few days, and on the 4th day the urine was of a natural color. Received in all, 69 grammes sulphonal in six weeks.

ABORTION.

BY EDMUND H. KASE, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

ALTHOUGH a great deal has been written on the management of these cases, there is still such an utter disregard of generally recognized rules among a large number of practitioners, pointing still to the uncertain knowledge which exists upon the subject, that another effort to formulate a code of action approaching unanimity, which should constitute the law of practice in the majority of the cases, may be pardoned. The loss of foetal life is enormous, and a vast number of these improperly treated cases ultimately fall into the hands of the gynæcologist. Surely there is a field open to the greatest improvements of obstetric practice. It must be born in mind that the symptoms of abortion vary with the period of gestation when it takes place; likewise the treatment also. Sometimes the ovum is cast off with a sharp pain and a few gushes of blood. These cases are exceptional. The cases that come to the physician are usually farther advanced, with considerable pelvic distress, labor-like pains and hæmorrhage. In a woman supposed to be pregnant these phenomena will at once suggest the probability that abortion is impending, and very often the prediction is verified. Yet occasionally we find cases that convince us that uterine hæmorrhage, or hæmorrhage from some part of the parturient canal is not uncommon in pregnant females that go on to full term.

The treatment resolves itself into: 1. The prevention of abortion. 2. The management of the process in case it cannot be prevented.

1. Prevention. Patients who show a tendency to abort should refrain from all excesses and irregularities as are commonly considered exciting causes of abortion. If the cause is due to syphilis or other

general defect, or diseased conditions of the ovum or attachments, the indications for remedies will doubtless plainly present themselves. These when carefully applied in conjunction with perfect rest and well-selected hygienic restrictions will insure a good degree of success. In those cases in which pain and hæmorrhage have already begun perhaps the most important of all means at our disposal for the relief of abortion is rest in the horizontal position. The patient should be kept in bed a week or longer after the colored discharge has ceased, and not allowed to sit upright or walk; for when the uterus is in an irritable condition there can be no doubt that the standing posture or considerable movement of any kind greatly increases the likelihood of abortion. The mind should be at rest, and the cause if possible should be ascertained. Hæmorrhage and pain within ordinary bounds should not lead the practitioner to feel that prevention is hopeless. In many instances the process may be prevented, and the possibility of success should not be abandoned until some evidence that expulsion of the ovum is going on. So long as hæmorrhage is not very severe and the cervix is not dilated and absence of proof of the escape of liquor amnii, abortion may be regarded as not inevitable, and an effort made to avert it. The diet should be light; excessively hot or cold things to be avoided. In case of retroflexion or retroversion of the uterus, it should be restored if possible by gentle manipulation in the usual manner, or by drawing the cervix downward and backward by means of a tenaculum or volsellum forceps and pressing the fundus forward and away from the promontory of the sacrum. When much difficulty is experienced the knee-chest position will facilitate matters considerably. To maintain the uterus in the state of complete restoration the introduction of a Hodge or elastic ring pessary will usually suffice. No drug alone can be relied on as a specific in threatened abortion. It is probable that such remedies as viburnum, sabina, arnica, actæa rac., pulsatilla, gossypium, secale and caulophyllum will be found most frequently indicated and serviceable.

The indications which should make us abandon all hope or intention of saving the ovum are sudden losses of blood to such an extent as to imperil the life of the mother, or such a drain as to seriously impair her health. On being called to a case of supposed abortion an examination should be made at once, if possible. It may happen that in cases of supposed abortion that there be no pregnancy at all. The examination should be done very carefully, lest the tendency to expulsion be increased. When abortion is

actively proceeding the ovum or part of it may sometimes be felt high up in the cervical canal, or it may be partly extruded from the os uteri. The first consideration in a case in which the symptoms of threatened abortion have occurred, is whether or not the ovum can be preserved. *Impress the patient or nurse with the importance of keeping everything which comes from the parturient canal.* Suggest that it be kept in a basin of water, which will facilitate its examination. Do not allow any of the discharge to be thrown out before carefully examining it. This will aid very materially in the treatment. Every clot and every portion of solid matter should be inspected carefully, otherwise the patient or nurse will lead you to think she has aborted, when it has not taken place. If on examination the ovum can be felt at or in the os-uteri, we may be certain that expulsion is only a question of time. As a rule, there is little or no hope of preventing the process after rupture of the membranes and discharge of liquor amnii.

2. Management of the process. If inevitable I believe that interference is unnecessary unless the hæmorrhage is excessive, or the evacuation of the uterus incomplete. If the ovum is expelled entire, this is usually the end of all anxiety. So long as rupture of the membranes can be prevented, our interference should be limited to controlling hæmorrhage. Thorough tamponing of the vagina is unquestionably one of the best means of checking hæmorrhage in threatened abortion. It may be done so effectively that no blood can escape. Uterine contraction is favored by the presence of the tampon in the vagina.

The Barnes bag introduced into the cervix is also an excellent means of controlling hæmorrhage, acting as a very efficient plug. *All examinations and introduction of instruments should be done under the strictest antiseptic precautions.* If the tampon is used it should be preceded by a vaginal douche of bi-chloride solution 1-2000, and the tampon inserted leisurely and methodically. Cotton is apt to shrink and allow further bleeding; consequently lint is preferable. Strips are cut about a foot long and several inches in width, and after being sterilized in bi-chloride solution 1-2000 are ready for insertion; they are packed one at a time, first well about the cervix and afterwards filling the vagina completely. The use of Sims' speculum will greatly facilitate their introduction. The tampon should not be allowed to remain over eight hours, and then repeated if necessary. On removal, the ovum will sometimes be found above the plug or in other cases the cervix will be dilated sufficiently to admit the finger to separate the mass from the uterus.

The Barnes bag, or vaginal tampon will usually be of great service in the majority of cases; but I think they are especially applicable in those cases where we can feel reasonably certain that the entire product of abortion still remains in the uterine cavity; and in those cases where we wish to prepare for more radical measures. In cases of incomplete abortion where the foetus has escaped and the placenta, or incipient placenta, remains behind, it is of greatest importance to effect an early and complete evacuation of the uterus, and it is here that energetic interference is eminently indicated, as the list of mortality is increased according to the length of time the membranes or placenta are allowed to remain in the uterus. In such cases I believe it to be entirely wrong to wait until signs of septic changes have taken place, even though the undue hæmorrhage has been greatly lessened. I am sure it is exceedingly bad policy, in fact, well nigh criminal, to allow the placenta to come away by the process of softening and decomposition, as we find is not infrequently done in the hands of the general practitioner, thus leading often to metritis, pelvic peritonitis, subinvolution, and the whole train of symptoms that may come from endometritis or other chronic uterine troubles that are apt to remain afterward, to say nothing of the risks of even fatal septicæmia. Though the principle of effecting an early and complete evacuation, where the placenta or fragments of it remain, is accepted by all good authorities, it is not universally carried out in practice. No amount of reluctance to take an anæsthetic, intolerance of manipulation or unpleasant feelings against digital extraction of the placenta should tempt the physician to leave the case to nature entirely, or even until decomposition occurs. After the foetus has passed, leaving the placenta in the uterus it is probably not good policy to wait even an hour before resorting to artificial means to clear the uterus of its contents. Occasionally we will find a patient so tolerant that the uterus can easily be relieved of its contents without the aid of an anæsthetic, the cervix being open enough to admit the finger nicely. But these cases are rare, and I am sure that you will agree with me when I say that owing to the want of co-operation of the patient, struggling from pain and fear, muscular rigidity, etc., the work necessarily is very imperfectly done. An imperfect evacuation is worse than no interference at all. The operation should be carried out deliberately and carefully. At least one assistant to administer the anæsthetic is required. The operation should be done without the use of instruments if possible. When any considerable portion of the placenta remains the cervix will

often remain open, thus facilitating the entrance of the finger at once, and by this means the placenta may be gently teased away. On the other hand the cervix may be closed up tightly; hence it is that we should always provide ourselves with good strong metallic cervical dilators. We should also carry Volsellum forceps, Sims' speculum, a dull wire curette, dressing and placenta forceps, all of which may be required. As to dilators Ellinger's will suit the majority of cases where the use of a dilator is necessary, but it is well to be reinforced with a heavier one, and here Goodell's will answer well. Atlee's dilator in these cases is of no value whatever. In some cases at first it may be difficult to pass the dilator into the cervical canal, but gentle pressure and a little skill will usually suffice. Even where the cervix is closed, but you feel fairly certain something remains, it is better to dilate and explore.

In the operation for clearing the uterine cavity the patient should be etherized, placed in the lithotomy position across the bed, the hips brought well to the edge of the bed and the bladder emptied. Cleanse the hands thoroughly. By means of a fountain syringe irrigate the vagina thoroughly with a hot solution of bichloride of mercury 1-2000. The cervix is drawn slightly downward, and dilated sufficiently to admit the finger; and in case the finger fails to reach or tease away the placenta augmented with pressure on the fundus through the abdominal walls, then the dull wire curette is to be called into action. Curetting is then done carefully and thoroughly; in this way the uterus can be effectually cleared of its contents, including any fragments of decidua or ova that may remain. Little or nothing of normal tissue is removed. A constant stream of bichloride water 1-4000 should keep the parts well irrigated, and finally injected into the uterine cavity until the water comes back clear. If the contents of the uterus have been found offensive, swabbing with tincture of iodine by means of dressing forceps or applicator, will be found of service and will also excite the uterus to contract. A thorough irrigation of the vagina with hot water should complete the operation.

In the after-treatment the patient must observe the same precautions as are required after ordinary labor, the patient is to remain in bed ten days to two weeks or more according to the severity of the case. The physician who will let a patient die of septicæmia by retention of a dead fœtus or placenta is guilty of nothing short of criminality.

In conclusion, a few words on the conduct of physicians in cases of criminal abortion may not be out of place. There can be no

doubt but that quite a number of the cases of abortion that occur are of a criminal character. Observation in the dispensary and private practice has confirmed this impression over and over again. In these cases, if abortion has already taken place and medical service is required there need be no hesitation in rendering it. But care should be taken to analyze every circumstance, and nothing should remain unexplained that could in any way incriminate the physician, as it is in this class of cases that most of the trouble involving the reputation and standing of physicians arises. Therefore, it is the practitioner's duty to take no part whatsoever in the concealment of the crime. There is no law requiring cases of abortion to be reported to the coroner. Nevertheless, to avoid unenviable notoriety when associated with cases of this kind, it is advisable to report to the coroner all cases at whatever period of gestation where there is probability of death of the mother, when reasonably certain of criminal interference; also those cases of a criminal character after four and a half months' gestation. This may be done in a confidential way, and will go far toward placing the physician in the proper light in case trouble arises.

There are few physicians, indeed, who have not been in contact with women applying for assistance in procuring abortion, the sole purpose often being to conceal the traces of an illegitimate pregnancy. There are others, especially in the married, where the woman has no idea of the enormity of the act, and that it involves the murder of a citizen and is a crime under all circumstances, unless done to save the woman's life. If this matter was presented plainly to the mind of these misguided women it would not infrequently result in dissuading them entirely from the furtherance of the act. Surely every conscientious physician feels the very great stringent moral obligations he is under, to object in every way to the crime contemplated and to positively refuse all co-operation. But the point I wish to make, and *protest most emphatically* against, is the *habit* of some physicians in giving even placebo or attenuated remedies to satisfy the demands of these cases. If a physician is so unwise as to *do this* or prescribe anything, however harmless or inadequate it is, to produce the desired result, he may easily place himself in the power of a designing woman and lay himself criminally liable, for courts have ruled that any attempt at producing this act, even if ridiculously inadequate, implies guilt. If the *intent only* is *proven*, failure or even non-existence of pregnancy is no presumptive evidence of the freedom from guilt or inculpation.

CHAMPAGNE AND DIABETES.

BY CLIFFORD MITCHELL, M.D., CHICAGO.

It is customary to forbid diabetic patients the use of champagne, and with good reason, though it is possible that some brands contain less sugar than others. I have, of late, used champagne in certain cases for the purpose of *early recognition of a possible tendency towards diabetes*.

My method of procedure has been as follows: Make up a solution composed of sulphate of copper, best, "iron-free," 30 grains; pure water, half a fluidounce; make perfect solution, and add pure glycerine, half a fluidounce; mix thoroughly, and add liquor potassæ, 5 fluidounces. The formula is the one well known to practitioners as that of Prof. Walter Haines, of Rush Medical College, Chicago. A perfectly clear, transparent, dark-blue liquid results, which, if bottled, will retain its virtues for thirteen years, possibly longer.

Champagnes, wines, beers, and urine may be tested for sugar with Haines's solution as follows:* Take about one fluidrachm of the test solution and gently boil it, when no change should take place; now add 6 or 8 drops of the liquor to be tested, and again bring to a boil, but do not boil too thoroughly and long. If sugar (glucose) is present, an abundant yellow or yellowish-red precipitate is thrown down; if no such precipitate appear, sugar (in urine) is absent, clinically speaking. Never use more than 8 or 10 drops of the urine or liquor to be tested. If sugar is abundant, one drop will cause a copious yellow-red precipitate with the boiling fluidrachm of Haines's solution.

I have tested various wines and beers with Haines's solution, and have found certain champagnes so rich in sugar that one drop will produce the copious yellow-red precipitate, equal to that caused by one drop of diabetic urine containing 4 to 6 per cent. of sugar.

The practical application of the test is just this: If the patient's urine is habitually above 1025 in specific gravity, and no sugar can be detected, cause him to drink a glass or two of such champagne

* Mitchell's *Clinical Study of Diseases of the Kidneys*, 2d ed., p. 369.

before retiring. Examine the urine voided on rising, and then see whether or not sugar can be detected. *In the urine of the healthy no sugar should be found.*

I have drunk a pint of sugar-rich champagne on an empty stomach and empty bladder. Examination of my urine, voided any time for four hours or more afterward with Haines's liquid, has shown no sugar at all, even with ten drops of urine. Now, on the other hand, I have a patient who habitually voids less than a quart of urine of specific gravity habitually above 1025 in the twenty-four hours' urine, sediment constantly of urates and uric acid. Let him drink but one glass of sugar-rich champagne, and *one drop* of his urine gives the yellow-red precipitate with Haines's liquid, though before drinking the champagne no sugar with ten drops can be found.

Now the question arises, is there a condition preceding diabetes in which the organism is just able to manage the ordinary starchy foods, but unable to grapple with liquids rich in sugar? If so, it is fair to suppose that by early regulation of the diet, the evil day of diabetes may be put off or possibly done away with altogether.

For the carrying out of the test systematically, a cheaper drink than champagne must be used. Any beverage, one drop of which, for example, gives the copious yellow-red precipitate with Haines's test liquid, can be substituted for champagne.

Incidentally, I have been struck with the purity of certain Milwaukee beers. One sample of export beer which I examined gave but an insignificant reaction, though ten drops were used; six drops gave no reaction at all. Whether these beers contain anything which interferes with the reaction, I have not yet ascertained.

The Haines's test liquid is useful, first, because it gives no "doubtful" reactions if less than ten drops of urine are used; second, because of the method of applying the test, an idea of the *quantity* of sugar present may be had. For example, if one to three drops of urine, added to a fluidrachm of boiling solution, produce a yellow-red precipitate, sugar is abundant; four to six drops, moderate; seven to ten drops, not abundant. A small quantity of sugar not detected by ten drops in the boiling solution may be suspected if, on cooling, the solution becomes greenish or turbid. But certain drugs in the urine will cause this turbidity on cooling; hence, the patient should be directed to let medicines alone for a day or two if traces of sugar are to be looked for.

Lastly, bear in mind the fact that sugar may be found in urine at certain hours of the day and not at others.

I make it a rule that patients, habitually voiding urine above 1025 in twenty-four hours' specific gravity, shall collect the urine of *each micturition* during the twenty-four hours, to be examined separately for sugar.

A CASE OF INVERSION OF THE UTERUS.

BY W. H. HOLSBERG, M.D., LEBANON, PA.

ON April 14, 1891, I was called to Mrs. W. T., in her third confinement. She had good health, and was of medium build. On making examination, the os was found to be dilated about the size of a half dollar. The pelvis was different from any I had ever met with, inasmuch as it was extremely shallow. There was no depth, as is often the case when the os can hardly be reached. On the contrary, it was very low down, just at the edge of the labia. The head had not yet engaged in the superior strait. Labor progressed favorably, so that in two hours the child was born, with no unusual symptoms of any kind. The uterus having promptly contracted, the patient was properly cared for, and I did not see her until about eleven hours after delivery.

On my arrival the patient informed me that an hour before she had voided the urine, and that "something had partly come away from her." I examined, and found the uterus inverted. There was positively no os to be found anywhere along the vagina or elsewhere, and, owing to the want of depth of the pelvis, this was not difficult to ascertain. The *uterus was very firmly contracted*; if I may use the comparison it felt as firm as a solid turnip and also as smooth; not a wrinkle; no rugous or irregular surface anywhere; not even a seam or dot marking the horns of the tubes.

This was an unpleasant state of affairs for me. The picture of a patient whom I knew for years, who had been in this condition, and told by her physician that all was well after he had returned the uterus so it would not project outside, but had not reduced it, with that patient, the uterus would become excoriated and cause suffering and worry; and as she would not agree to extirpation, various compromising measures in a mechanical way, as well as operation, were resorted to, but with poor rewards for the trouble.

Her husband objected to any attempt at reduction, saying, that if it would not kill her at once, she should not be interfered with. However, next day, on making another examination, I found the uterus not so firmly contracted, and about one-third greater in size. I proposed to give the patient ether, and Dr. J. F. Peterman kindly gave the anæsthetic.

After she was nicely under the influence, I proceeded to the task, having visions of the wonderful instruments and methods as shown in the books, the former of which I did not have on hand. The uterus was thoroughly relaxed, there being no contraction nor hæmorrhage; and by simply introducing my hand, which had been thoroughly washed, into the vagina, and, pushing the flabby uterus before it, it was easily reduced, there being as little resistance as from lifting a wet towel if it were thrown over the head. This was unexpectedly easy. But now for the contraction of the previous day,—that was wanting. Friction within the uterus or kneading outside did no good. I could not remove my hand. It was then decided to give a hypodermic injection of a solution of ergot. After some little while the contractions came on, and soon with sufficient force to expel the hand, and no further difficulty was experienced.

Cases of this kind are not plenty, and when they do occur the inversion should be reduced as soon as possible.

REST CURE IN INCIPIENT PHTHISIS.—Keating, in a paper read before the El Paso County Medical Society, invites criticism upon the above subject. He believes that many cases of phthisis which have a fatal ending would have recovered if given rest. He thinks it is a mistake for patients to rush madly into out-door life. He believes that a rest cure, combined with inhalation of oxygenated air, will be one of the best means to combat phthisis. He thinks at the health-resorts the cottage system should be used. This paper was discussed fully by experts, and they all agreed with the views expressed. Most speakers advised a modified rest cure, and not one carried out in all its details.—*University Medical Magazine*, April, 1892.

A FORM OF PAINFUL TOE.—Guthrie described a form of painful toe akin to anterior metatarsalgia, described by Pollosson in 1889. It differs from the latter, however, in that only the distal phalangeal joints are involved. In either case, under the influence of long standing or walking in tight boots, the ligaments of one or more joints, metatarso-phalangeal or phalangeal only, become strained, slight subluxation takes place, the nerves are stretched and pressed upon by the partially dislocated bones, and the characteristic pain is produced. The pain occurs suddenly, and with a sense of something giving away at the site of the joint affected. It is relieved by taking off the boot and pressing the displaced bones into position. The reduction is always accompanied by a sharp twinge of pain, followed by instantaneous relief. The author reports one case in a man who could not take the necessary rest, which he cured by directing him to wear a boot with a very broad sole, slightly convex on the upper surface, so as to support the sunken head of the metatarsal bone, and with plenty of room across the base of all the toes.—*The Lancet*, March 19, 1892.

EDITORIAL.

THE MEDICAL NEWS AGAIN.

THE offensive sectarian who edits the *Medical News*, again, with Bourbon-like fatuity, renews his attack upon homœopathy and the physicians who avowedly support the truth, that scientific therapeutics is governed by the law of similars. He again plunges into a mendacious, mud-slinging campaign that robs him of his self-respect and disgraces the journal entrusted to his care.

From an editorial, April 9, 1892, under the caption "Medical Nihilism in Ohio," it appears that the allopathic, homœopathic and eclectic physicians met together and formulated an upright and just medical bill for the approval of the State Legislature. Owing to influence exerted by certain outside parties the bill was ignominiously defeated. The presumptuous editor of the *News* seizes upon the occasion to read his honorable confreres a Caudal lecture on their disgraceful (*sic*) combination with "homœopathic and eclectic quacks" in protecting the public from unqualified practitioners. There is a lesson here for both the editor of the *News* and for physicians of the homœopathic school. The former has an opportunity to take his first instruction in the ordinary requirements of a gentleman; he will profit by following in the footsteps of his Ohio confreres. The latter are compelled to recognize that while certain physicians of the old school, gentlemen in every sense of the term, in Pennsylvania are anxious to effect a combination with the homœopathic fraternity by which a bill, just to all, shall be formulated and presented to the next legislature for approval, the execution of which while entrusted to honorable men would work no injury to any one, if the control should pass, as it is likely to do, into the hands of a group of narrow-minded sectarians, bigotry and prejudice will tend to warp an honest construction of the law. It will be the height of folly to listen to anything but absolute control of the examining and licensing of our own applicants.

The following week this pretentious editor—the guardian of the ethics and morals of the physicians of the old school of medicine—pours out his vial of adulterated wisdom on consultation instructions. An inexperienced party writes to the experienced editor of the *News* as follows:

"There is a man who tried to graduate from the University of Pennsylvania, but failed three times. He then attended some homœopathic college and graduated. He prescribes for or treats patients according to whichever school they wish. As a young physician I am advised to keep clear of him, yet Dr. —, an elder graduate, meets him, particularly when there is a \$10 bill waiting. Dr. — is a member of — County Medical Society, and if it is right for him why not for me, who need a \$10 fee more than my elder brother? Yet I have refused three consultations, or \$30, for fear that I would be violating that code held so sacred by physicians. Sometimes good physicians blunder on these so-called quacks, meet at the bedside, discuss the case privately, advise as to future treatment, collect \$10, but say that no consultation has been held. What is right? What is wrong? Tell me that I may know if I am justified in foregoing the money I, as a struggling young man, so much need."

Instead of answering the question on its merits the opportunity is taken to heap abuse upon the graduates of the Hahnemann Medical College of Philadelphia. In replying, he says: "There are three classes of medical practitioners—physicians, sectarians and quacks—the physician is catholic, the sectarian is exclusive and the quack is commercial." As the editor and his fellows deny—that is openly—homœopathy and its accumulated experience of a century they are therefore not catholic, consequently, setting in judgment upon themselves, they are not physicians. As they deny scientific therapeutics—homœopathy (no matter what they may practice)—they are exclusive and are necessarily sectarians. We hope that they are not commercial. This editor, and many others like him, forget that a few years ago there were men in the profession with just the same intolerance of the opinions of others, who forced their brethren then interested in the teachings of Hahnemann out of their societies and into a new organization; this was done because these men were honest, and when they recognized the truth of homœopathy they followed it openly and scorned to adopt the methods of introduction since used by Phillips, Ringer, Bartholow, Aulde and hundreds of others. It is always dishonest to steal and palm off as your own the results of other men's toil and research, even if your therapeutically starving brethren are crying for nourishment. When this compulsory separation took place the members of the new school of medicine did not "*reject* the accumulated experience of the profession" that was worth preserving, and they still "*accepted* all aid *actually* furnished by anatomy, physiology, pathology and organic chemistry." The position of the homœopathic school to-day remains

just exactly the same. We regret that our old-school brethren have not as yet absorbed the spirit of tolerance and liberty.

The editor then proceeds to give his requirements for consultation: "If those graduates of the Hahnemann or any other sectarian college, who have abandoned Hahnemannian practice—and only such ask for consultation with physicians—would publicly renounce their previous contentions in favor of the exclusive truth of the so-called 'law of similars,' drop the name of 'homœopathy,' and submit to examination by a properly constituted committee of any State or county medical society, we would not oppose their admission to that society, and their full and free recognition as physicians."

These gratuitous conditions, and the editor's condescension, are asinine. To what debasement have the pages of the once respectable *News* come.

The commercial value placed upon homœopathy by this editor is but the misconception of an envious mind. An enlightened public, from bitter experience, has learned something of the absurdities of "regular" therapeutics—and they are done with it. As the public learns more of the therapeutic duplicity that is now practiced by the old school of medicine their contempt will be heightened and the success of those who openly practice what they believe will be still greater.

In giving the advice requested in the communication this editor can grasp but two ideas, "homœopath"—this is his *bête noir*—and "dollars." The question of the "homœopath" can be dismissed at once. No reputable homœopathic physician would ever seek the advice and assistance of so irresponsible a tyro as the correspondent certainly is, if he is not fictitious, nor would he have any call for the services of the sectarian editor himself. His commendation of the young man's resistance to the almost irresistible yearnings for the supposed homœopath's dollars verges on the ludicrous, still we heartily endorse it. Here he ends. Not a word more. This is the sum total of the advice given to the sorely tempted penitent by the father confessor of allopathic morals and ethics. Has he and his kind no humanity? What about the poor victim of misplaced confidence? Do they let him die without an effort on their part because his attendant claims to use homœopathy? It seems so. It was not humanity that prompted the inquiry of the correspondent. There is no thought contained as to his duty as a man and a physician. The whole burden of the complaint is simply a craving for lost dollars and a fear of professional ostracism for breaking a code that

is to-day a disgrace to civilization. The candid statement on the part of both of a full knowledge of the attending physician's ignorance and utter incompetency, the utter disregard and heartlessness for the suffering patient, while they whine and rave about "homœopaths" and the "dollars," is despicable. We suggest to this virtuous editor and his correspondent, for their adoption, that *the first duty of the true physician is to restore health to the sick.*

OBITUARY.

PROFESSOR LEMUEL STEPHENS, M.D.

PROFESSOR LEMUEL STEPHENS, M.D., died at his residence, Philadelphia, on Friday, April 1, 1892. He was born February 22, 1814, at Plymouth, Mass., where his parents held a prominent position among the advanced thinkers of their time. He received the rudiments of his education in his native town, and in 1831 he entered Harvard University, where he graduated in 1835. He continued his education in the Universities of Göttingen and Berlin, in Germany, earning the reputation, which he since enjoyed, of being one of the finest chemists in this country.

After his return from abroad he taught five years in the University of Pittsburgh, when the chair of Chemistry and Physics in Girard College was given him. For thirty-six years he not only did vigorous teaching there, but, with his genial nature, he supplied to the orphan boys of that institution almost a father's love and interest. Many of them came to him for help and encouragement during their lives.

For more than twenty years he was a member of the Faculty of the Hahnemann Medical College, filling the chair of Chemistry with marked ability. In addition to his other duties he was analytical chemist to the Gas Bureau.

Professor Stevens's remains were interred in Plymouth, the home of his childhood, where he always spent his vacations.

On the twelfth of January, 1892, the wife of C. F. Bingaman, M.D., of Pittsburgh, Pa.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D.,

FRANK H. PRITCHARD, M.D., AND EDWARD M. GRAMM, M.D.

ÆTIOLOGY AND GENERAL PATHOGENESIS OF THE VARIOUS FORMS OF BRONCHITIS.—Dr. Marfan has made a very exhaustive study of this subject. Certain professions are especially liable to bronchitis as actors, preachers, professors, elocutionists, etc.

Causes of acute bronchitis. Five groups may be distinguished :

1. Specific infectious bronchitis.
2. Non-specific infectious bronchitis.
3. Toxic bronchitis through elimination.
4. Bronchitis by physio-chemical toxic action.
5. Bronchitis from anglo-neuroses.

1. *Specific Infectious Bronchitis.*—The bronchitis of the grippe, whooping-cough, and measles, is an example of this class, *i.e.*, the bronchitis is an essential element of the disease, without which the picture of the disease would not be complete. In diphtheria the disease may extend and give rise to a bronchitis, the so-called pseudo-membranous diphtheritic bronchitis. In these mentioned diseases the bronchitis is descending.

The pneumococcus is frequently the cause of a purulent or fibrinous bronchitis, accompanied with or without pneumonia. Erysipelas may either primarily or secondarily attack the bronchi, and the erysipelatos tracheo-bronchitis results. Its course is descending. Lodge has described a mortal form of bronchitis, seen in wool carders, from breathing in the spores of the anthrax micro-organisms. Besides these forms of bronchitis of exogenic origin, there are also other forms where the disease is of hematic origin as in smallpox, where the eruption may come out on the mucous membrane, and often produce a false membrane. In malaria an intermittent bronchitis is observed; in glanders the tracheo-bronchial eruption is often accompanied by a diffuse inflammation of the mucous membrane; in secondary syphilis the eruption may involve the bronchi and finally, in pemphigus of the skin the disease is often accompanied by an eruption in the bronchi and trachea.

Infectious Non-Specific Bronchitis.—In this class the influence of micro-organisms is evident yet of secondary importance; bronchitis from cold is a type of this class. The bronchitis of adynamic diseases is of the same order, and has the same pathogenesis.

Bronchitis from Cold.—Acute is sometimes produced by the inhalation of cold air, not from immediate contact with mucous membrane of the bronchi but from chilling the surface of the skin. In animals exposed to cold after a previous exposure to warmth, the cutaneous vessels are seen to dilate, and the blood to circulate there with force and abundance. If the cold is sudden and severe the blood is chilled in masse, and by repercussion profoundly influences the whole organism. But experiment does not show how internal lowering of the temperature produces bronchitis. This disturbance of the equilibrium of the circulation in the bronchi, probably give the micro-organisms a port of entrance and a bronchitis is set up. A similar action is seen in adynamic diseases, as typhoid fever, where bronchitis is the rule, yet here the bronchitis is of a secondary element. True broncho-typhoid if it exists, is a great rarity. All adynamic states may have this form as a complication, as infectious endocarditis, diphtheria, cholera, scurvy, cerebro-spinal affections, malarial cachexia, Bright's disease, syphilis, diabetes, gout, alcoholism, cancer, etc., and the bronchitis of the dying, the death-rattle of the laity. In these adynamic, cachectic, and agonic states bronchial stasis is not due only to vasomotor innervation, but also to a weakened action of the heart which has such a remarkable action on the bronchial circulation.

Toxic Bronchitis from Elimination.—There are certain substances which are eliminated by the bronchial mucous membrane, as iodine, bromine. The bronchitis of iodine is, according to Germain-See, a matter of no importance. That of bromine is more severe, and, if grave, points to the use of the remedy in large doses. Poisoning by cantharidine gives rise to a tracheo-bronchitis.

Bronchitis from Toxic Physio-Chemical Origin.—The inhalation of dust suspended in the atmosphere may produce a bronchitis. Penetration of putrescent particles of food into the bronchi may, especially in the insane, produce a bronchitis. The respiration of certain gases also will induce bronchitis. The sulphohydrate of ammonia of the cesspools is a cause of bronchitis in the cleaners of these. The vapors of nitric acid, loaded with picric acid, produce in the workmen who manufacture melanite a special form of bronchitis, with asthmatic attacks. Chlorine, acetic acid, hydrochloric acid, sulphuric acid, nitric acid, and especially nitrous acid, produce analogous effects. The vapors of nitrous acid act on the mucous membrane of the bronchi even to gangrene.

Bronchitis from Angioneuroses.—In this group one finds the bronchitis from fevers due to sewers, the asthmatic bronchitis which often intervenes in chronic bronchitis and urticaria of the bronchi. In these forms there is a vaso-dilatation of the bronchial vessels, which is of longer or shorter duration. The phenomenon is temporary.

Causes of Chronic Bronchitis.—This form is either primary or results from the repetition of the acute form. But the same causes which produce chronic bronchitis also favor the passage of the acute to the chronic form. These are a diathesis, a chronic naso-pharyngeal disease, a chronic disease of the lungs, pleura or mediastinum in an affection of the heart or the bloodvessels, and in an insufficiency of the kidneys.

Chronic Bronchitis of Neuro-Arthritics.—The writer admits the existence of such a bronchitis of neuro-arthritic origin, i.e., under the influence of civilization many influences, as intellectual, moral, or physical excesses, alcoholism, syphilis, etc., have brought about hereditary degeneration of the race. These degradations are to-day seen in the nutritive functions; hereditary trophopathic diseases; arthritism or the diseases from slow nutrition, as described by Bouchard; or in the functions of the nervous system. Sometimes these two are combined. In these hereditary neuro-arthritics one observes forms of bronchitis which are more or less directly connected with the diathesis, as, for example, the asthmatic bronchitis, gouty bronchitis. True, gouty bronchitis is extremely rare. That of gouty persons is generally of cardiac, albuminuric, or asthmatic origin. Dilatation of the stomach may also be present in cases of chronic bronchitis. In short, neuro-arthritism may produce a chronic bronchitis either directly, through an asthma, or a dilatation of the stomach.

Bronchitis from Chronic Naso-Pharyngeal Diseases.—Frequently neuro-arthritic patients suffer from chronic naso-pharyngeal diseases and bronchitis, the bronchitis, no doubt, being due to the mouth-breathing.

Bronchitis from Chronic Lung, Pleura, and Mediastinum Diseases.—Bronchitis often accompanies pulmonary congestion, pulmonary emphysema, and all chronic pulmonary diseases, as pulmonary phthisis, where there is an infective non-specific bronchitis. Chronic bronchitis, localized at the apex of the lung, is symptomatic of tuberculosis. Chronic bronchitis is observed as a consequence of pulmonary atelectasis, due to a pleural effusion or a mediastinal tumor.

Cardiac Bronchitis.—Cardio-vascular diseases are among the frequent causes of chronic bronchitis, and bronchitis is the rule in nearly all heart diseases.

Albuminuric Bronchitis.—Bronchitis is a common complication of renal diseases. They are produced either by the weakness of the heart muscle or by the effect of the uræmic poison on the bronchial vessels or through the medulla oblongata. The bronchitis of Bright's disease is of cardio-uræmic origin. A purulent collection in the kidney, pleura, liver, may burst into the bronchi and give rise to a bronchitis.—*Rivista Clinica E. Therapeutica*, No. 1, 1892.

GLANDERS TREATED WITH SUCCESS BY INUNCTIONS OF MERCURIAL OINTMENT.—Dr. Gold, of Odessa, Russia, has successfully treated a case of glanders with inunctions of gray salve; some time ago he reported a case which he had cured by this means and now he adds a new one. The patient was a man, thirty-two years of age who presented a hard lesion on the inner side of the right thigh, which, on incision, was found to contain pus, and which the writer at once thought might be

glanders. Bacteriological examination of the pus showed him to be right, as the bacilli of glanders were discovered. Inoculation in guinea-pigs, and on culture-plates of the dead animals' splenic fluid, developed a pure culture of the bacilli of glanders. Besides antiseptic treatment inunctions of gray salve were made, in all sixty-two applications, and the patient recovered. The writer regards the patient as saved from a certain death. Diagnostically the writer emphasizes the importance of recalling glanders when one meets with superficial and torpid cutaneous infiltrations, or pus-foci, and in such cases to not forget to surely make a bacteriological examination and control inoculation.—*Norsk Magazin for Lægevidenskab*, No. 2, 1892. In the year 1890, a Missouri physician cured himself of this fatal disease by inunctions of gray ointment and the internal use of the iodide of potash, in massive doses. He then claimed that he was the only man on record who had ever recovered from the glanders. That same year the writer published his first case where a cure was obtained by nearly the same means, mercurial ointment. A careful examination of the international literature, at the time revealed the fact that some few persons had had the glanders and had recovered, all from the use of such remedies as mercury or the iodides. These were some six in number, and were scattered over about forty years. Cases of glanders in man are frequent enough in the medical literature, but they almost invariably perish. This is not homeopathy, but in such a disease one is grateful for any suggestion.—*Ed.*

ERUPTIONS FROM IODINE.—Dr. Gemy, of Paris, finds that the eruptions produced by the iodide of sodium may be divided into two classes. The former comprises nearly exclusively a superficial, papulous, papulo pustulous, subacute and uniform epidermitis, the so-called iodic acne. The second consists of either simple, urticaria-like nodular, circinate, bullous or hemorrhagic erythema. It may also consist of acneiform, furunculoid, anthracoid, nodular or necrobiotic epidermatitis, or dermatitis. The writer passes over the ordinary iodic acne, which is generally well known and at the same time benign, to devote this work to the second variety, at the same time referring, in all their details, to three cases observed by him; they were each very different and very interesting. The eruption appears some days after beginning treatment with iodine, the general condition of the patient remaining good. It begins with erythematous spots, which itch exceedingly. After 18 to 24 hours there appears in this spot a papule of the size of a small lentil, which soon is transformed into a pustule. This elementary and characteristic lesion is a small reddish livid swelling, crowned by a vesicle and containing pus. There is a hair in the centre. These lesions generally group themselves together and assume the form of agminate lesions of folliculitis and perifolliculitis. The geometric spots consist of a great number of elements and vary greatly in dimensions. The disseminated lesions occupy the beard and hairy scalp. According to the various degrees of development one observes the anthracoid, pustular, or tuberculous forms; the bullous form is most frequent in the face. A more or less cedematous zone of inflammation surrounds the lesions, which may be isolated or agminated; the œdema in some regions where the subcutaneous tissue is loose may assume vast proportions. If the administration of the remedy be suspended as soon as the eruption is once out, there will be no further manifestations. In case it be not left off, the eruption will assume great proportions; the number of eruptive elements increases, the patches enlarge, the entire eruption becomes covered with a yellowish, brilliant, thick, honey-like crust, from under which flows, through the fissures, a serous or sero-purulent, or even sero-sanguinolent fluid. The bullæ, completely distended by their contents, terminate by rupturing, thus forming an ulcerated surface. Often, even when the remedy has been suspended at once, the lesions have such a rapid development that they leave behind permanent scars; ordinarily when the drug is suspended the entire exanthem is arrested in its course; in a few days all the pustules and papules throw off their crusts, leaving a livid red surface, which represents the papillary stratum, the pustules which have not suppurated collapse, the bullæ persisting some days after. After the suppuration of the pustules and the distension of the bullæ, there remains an ulcerated surface, more or less depressed, with regular geometric margins, implicating the papillary stratum. This is covered with fleshy granulations. Cicatrization lasts from 15 to 20 days. The subjective phenomena reduce themselves to a sharp pain upon pressure, and a spontaneous burning and troublesome sense of tension. The resulting cicatrices are characteristic: First, vegetating, with almost fibrous bands, then depressed, granular, whitish, and atrophic. The prognosis is always the most serious, not as to a fatal result, which also has been observed, but with regard to the indelible cicatrices. There is no

especial pathological anatomy of these lesions. It is extremely easy to confound this disease with syphilis, but a careful examination will show the color of the lesions to be less pronounced than in syphilis, and the absence of vesico-pustules.—*Giornale Italiano Delle Malattie Veneree e Delle*, December, 1891.

TROPHIC CHANGES OF THE NAILS IN MULTIPLE NEURITIS.—Dr. Bielschowsky, of Breslau, finds the nails in multiple neuritis to undergo many changes. They lose their gloss, become uneven, brittle, split, crack or fall off entirely. The following changes have as yet not been described: A 40 year-old man, suffering from gastro-enteritis, was seized with weakness in the legs, arms and hands, and an accompanying distinct feeling of numbness in the parts affected. It was impossible for him to be on his legs or walk about. With this the disease seemed to have reached its highest point, gradually to retrogress; five months after the patient was completely restored. The diagnosis, neuritis, was made on account of the motor paralysis and anaesthesia. Pressure upon the nerve trunks of the left arm was painful; there was faradic irritability, and the cutaneous and tendon reflexes were absent. While the disease was in retrogression the patient noticed that the base of all his nails presented numerous white points, which soon increased in length, as well as in breadth. These points increased in width until a broad strip crossed the nail from one side to the other. The remainder of the nail was normal. They did not recur. The toes did not present anything abnormal. Vogel has described similar white stripes in the nails of persons who passed through fevers (*Die Naegel bei Fieberhaften Krankheiten*, *Deutsches Archiv Fuer Klinische Medizin*, 1870) in convalescents from typhoid fever and exanthematic typhus, where the first indications of the disease appeared from four to six weeks after cessation of the fever. These stripes in the nail were succeeded by irregularities in its substance. The whole nail lost its glossiness. Morison (*Vierteljahrsschrift Fuer Dermatologie und Syphilis*) describes a similar case in a lady who was apparently entirely well. Microscopic examination of the nails showed them to be full of empty cells filled with air.—*Norsk Magazin for Laegevi Denskeben*, No. 2, 1892.

ETHER AND CHLOROFORM.—Ether is less harmful than chloroform, and while neither paralyzes the heart when administered with plenty of air, this organ would beat much longer during asphyxia combined with ether than with chloroform. The latter is like a sharp knife as compared with a dull one; it is more efficient, for good, if properly handled, but more powerful for evil if misused (T. Lauder Brunton). In organic disease of the nervous system, chloroform is preferable, as well as in operations about the head and upon the brain, on account of its well-known action in producing cerebral anaemia. In diseases of the heart ether is to be preferred; chloroform is especially dangerous in fatty degeneration, as it produces dilatation, and, owing to the loss of resiliency, the heart muscle fails to contract. Mere valvular disease, however, makes but little difference in the prognosis, except in so far as it indicates a change of structure in the myocardium. Lung disease calls for chloroform, provided the heart presents no contraindications, as it is less irritating to the mucous membranes of the air passages and produces less excitement; such cases are dangerous at best and must be watched with the greatest care. Diseases of the kidney have no influence either way, and ether does not cause nephritis or produce suppression, as claimed by some. Of blood conditions, anaemia is the most dangerous, while disease of the vascular coats is another condition requiring particular care and attention. No position is safe, especially in using chloroform, except the supine one with the head well extended. The lateral position is to be avoided if possible, as it not only interferes with respiration but favors heart failure. It is becoming more and more accepted that ether is the much safer anaesthetic, and it should always be used, unless strongly contraindicated. The method of administering nitrous oxide and following it with ether has much to recommend it. (Dudley Buxton).—*British Medical Journal*.

HERPES ZOSTER OF THE MUCOUS MEMBRANES.—Dr. Henri Fournier has observed three cases of herpes zoster of the mucous membranes, and after a careful study of the disease, concludes as follows:

1. Herpes zoster of the mucous membranes is very rare. It invades the field of the trigeminus, the branches of which may be either singly or collectively attacked. It may be limited to the mucous membrane or simultaneously also invade the skin.
2. It may appear suddenly or with malaise, associated with a certain degree of fever.

3. Locally it is characterized by a short stage of vesiculation, followed by a period of erosion, and even ulceration; in the majority of these cases the pain ceases in this third stage.

4. It is generally unilateral, yet it is in very rare cases bilateral.

5. When the lesions are confined to the superior maxillary nerve one should be careful not to confound it with herpetic angina, the differential diagnosis of which is at times difficult.

6. Recurrences are very infrequent.

7. It is in many cases of nervous origin. In some cases one must admit it to be a nervous disease of infectious origin.—*Sandowzy's Theory, Giornale Italiano delle malattie veneree e della Pelle*, December, 1891.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNER, A.M., M.D.

THE SURGICAL TREATMENT OF STONE IN THE KIDNEY.—(1) A diagnosis can be arrived at from

(a) "Suggestive" symptoms: an increase in the solid constituents of the urine, which appear in a crystalline form; with these are associated pus, muco-pus, blood or other plastic elements. The more decided and continuous these manifestations, the more significant they become. Renal pain, of varying intensity and duration; lumbar aches; vesical irritability; wandering pains in the loins, urethra, thigh and the testicle, which is hyperæsthetic and retracted. Chronic indigestion, nervous prostration, and a lithæmic state complete the "suggestive" picture.

(b) "Convincing" symptoms: these follow the above, almost imperceptibly at times, and are largely an exaggeration of the same. Renal colic, prolonged and severe; lumbar pain, more or less constant and aggravated by bodily movements; pus and blood in the urine, the latter increased by jolting and jarring; renal epithelium, at times with blood-casts; tenderness of the kidney on deep pressure, which may show the organ to be enlarged. Sounding, washing, and inspection of the bladder with the cystoscope will exclude the presence of an abnormal body in that viscus, and the latter method may show the entrance of blood from one of the ureters. It should be borne in mind that stone in both kidneys is the more common condition, and that the presence of stone in one kidney may produce reflex pain in the other, giving reason to suspect its presence in both or even in the healthy organ alone.

Indications for operation:

(a) Exploration should be advised when the "suggestive" symptoms are persistent and annoying, and have not been benefited by milder methods of treatment.

(b) Operation should be urged in the presence of "convincing" symptoms which show irreparable kidney changes.

(c) In a healthy kidney the stone should be removed by nephrotomy.

(d) When more or less extensive suppuration has been set up, the question is between nephrotomy or nephrectomy. This will depend on the extent of the disorganization of the organ. In pyelitis, incision will be sufficient, and even when the substance is involved, thorough drainage should be preferred to removal, unless the indications for the latter are clear. This is on account of the importance of preserving any functioning portion of the organ in view of present or future disability of its fellow. In almost any case a secondary nephrectomy is much safer than a primary one.

(e) The same indications apply to cases of stone secondary to and caused by pre-existing pathological kidney changes.

(3) *Operative treatment.*

Stone in the kidney requires, then, a nephrotomy or a nephrectomy, and these operations, as well as simple exploration, can be carried out through the abdomen (trans-peritoneal method), through the loin (extra-peritoneal method), or by a combination of both.

(a) The trans-peritoneal route requires an incision along the outer border of the rectus muscle, and a second one outside the colon to avoid its vessels. The field of

this operation is restricted to single, small stones in healthy non-suppurating kidneys, and to non-calculous affections of the kidney.

(b) The combined method is the one advocated and practiced by Thornton (see *HAHNEMANNIAN MONTHLY*, vol. xxv., p. 124, February, 1890).

(c) The posterior, or extra-peritoneal method, is the one to be preferred, and is considered the safer one.

The incision may be transverse or longitudinal, or a combination of the two; in either case the patient is rolled on the side, and the trunk is flexed so as to increase the space between the ribs and ileum. The longitudinal incision is made along the border of the sacro lumbalis, and extends from the eleventh rib to the ileum. It is carried through the skin, then deepened layer by layer until the aponeurosis of the transversalis is reached and divided, exposing the quadratus lumborum. When this is drawn to one side, and, if necessary, divided close to its iliac attachments, the perineal fat can be seen moving up and down with the acts of respiration through the thin anterior layer of the lumbar fascia. By dividing the latter, and by tearing and stripping off the fat toward the sides, the middle and lower portions of the kidney and its pelvis can be seen and palpated. Both incision, when the subject is not too fat, and excision, when the organ is not too much enlarged, can be done through this opening, which does not weaken the abdominal wall, and lessens the risk of wounding the peritonæum. There is danger, however, of wounding the pleura (which has proved fatal), owing to the absence of, or a rudimentary twelfth rib (five per cent.); hence the ribs should be counted before the operation is begun. Occasionally, the last two ribs have been resected, or they can be drawn upward with a blunt hook. The transverse incision begins at the edge of the sacro-lumbalis below the twelfth rib, and is carried outward parallel to the latter about four inches. Additional room can be gained by combining with this a short longitudinal cut at the spinal end. This incision is especially adapted for nephrectomy with large kidney; through it the peritonæum can also be opened to aid in securing the pedicle. To accomplish a preliminary ligature of the renal artery, a longitudinal incision may be made a little in front of the axillary line, and the perinæum stripped back until the vessels are secured.

Exploration of the exposed kidney is accomplished by grasping it between the thumb and finger and carefully palpating it, or it may be explored with a fine needle which is passed through the parenchyma and wall of the pelvis at intervals of about half an inch until every portion of the organ has been systematically examined.

The kidney is best opened through its substance as the hæmorrhage is more readily controlled, and the danger of urinary fistula is decreased. The stone may be turned out without difficulty, or this may require division of septa, opening of pouches, crushing, or even nephrectomy. When there are several concretions, one or more are often overlooked, and this may occur too if but one is present. The ureter is then explored, and, if it contain a concretion, this is either pushed downwards, picked out, or washed out with a stream of water. The kidney is then sutured and the wound drained, packed with gauze, and only partially closed.

Nephrectomy may be very difficult on account of inflammatory involvement of the fatty capsule, but it is quite easy otherwise to separate the organ from its attachments until a sort of pedicle is formed of the ureter and vessels. These can be ligated in sections by means of an aneurism needle, or the pedicle can be tied *en masse* by the elastic ligature or clamped. These manipulations should be very gentle, and forcible traction on the kidney should be avoided. In the presence of inflammatory adhesions, still greater care should be exercised as the peritonæum, colon, or even the vena cava have been torn. It may be advisable under these circumstances to excise the posterior portion of the organ, and curette the anterior portion as far as it is deemed safe; wound healing will be retarded of course by this procedure. After excision of the kidney the wound is packed and drained, the ureter being ligated if it has been separated.—Bryant and Stimson (New York), *Annals of Surgery*.

TREATMENT OF CYSTITIS BY CORROSIVE SUBLIMATE SOLUTIONS.—F. Guyon (Paris), gives the results of a number of experiments made with a view of testing the value of this drug in vesical inflammations.

Irrigation was tried in ten cases with two cures, two ameliorations, and six failures; *instillations* in eighteen cases, resulted in cure in ten, in two of which irrigation had failed; marked amelioration in six; improvement, that is diminished pain, in two.

Of the varieties of cystitis there were the following: tubercular, ten cases; blenorragic, seven cases, two acute and five chronic; "prostatic," two cases; pseudo-membranous, one case; of varied origin, six cases. Among the tubercular two deserved to be called cured, but owing to the character of the disease and the lack of microscopic proof, they are termed marked ameliorations. In three others, in which the bacilli were demonstrated, the same result was obtained. This proportion of successes is noteworthy in view of the fact that topical applications of other drugs, notably nitrate of silver, as well as naphthol, creosote, and lactic acid, invariably aggravate the symptoms, while iodoform has, in the hands of the writer, been without effect. In all these cases the sublimate was well borne. Constitutional treatment should be carried out at the same time. In the seven cases of blenorragic cystitis, the two treated by irrigation were failures, and of the five treated by instillations, three were cured, and two very markedly improved. It should not be forgotten, in this connection, that nitrate of silver gives most brilliant results in these cases. The sublimate gives equally good results in acute cases, and should be borne in mind in the frequently obstinate, chronic ones. The two cases of cystitis in patients suffering from prostatic hypertrophy, were promptly relieved by instillations after irrigation had failed. Here again this drug should not be forgotten in this rebellious class. Among six cases of varied origin, instillation cured two, while irrigation cured once, improved once, and failed twice. The single case of pseudo-membranous inflammation was cured by irrigation. Comparative chart tracings show that as the frequency of urination decreases the vesical capacity increases, showing the latter to be, as previously claimed, not anatomical but physiological. This relative difference was particularly marked after instillations, less so when these had been immediately preceded by washing.

As to the technique, the instillations are to be made just inside of the deep urethra, which is always involved. The amount injected should not be over twenty to thirty drops at first, but may be increased, if tolerated, to sixty drops or even twice as much. Pain is the guide. The strength employed varies from 1 to 5000 up to 1 to 1000, or even stronger. The former should always be used at first; 1 to 3000 represents the average. In a general way, the quantity should be decreased as the strength is increased. Clearing up of the urine is the criterion of success; diminished pain and frequency of micturition the concomitants. To obtain the best results, the bladder should be empty, hence the patient must urinate before the operation. If there is any doubt as to the sufficiency of the bladder, or if there is an abundant sticky discharge, the organ should first be emptied or washed with boric acid solution. The amount of this injection will depend on the sensibility of the organ, and, if this is excessive, it should be dispensed with altogether until the instillations render it more tolerant.—*Annales des Maladies des Organes Genito-Urinaires*.

A NEW CURE FOR HERNIA.—Shimwell (Philadelphia) suggests a novel plan for removing one of the causative factors in the production of hernia; that is, the well-known lengthening of the mesentery. As the result of experimental researches on the lower animals, he proposes to do an abdominal section, draw out successive portions of the intestine, fold the mesentery over on itself, and hold it in this position by interrupted sutures.—*Times and Register*.

SEQUESTRUM IN THE BLADDER.—Desnos (Paris) met with a sequestrum, probably of pubic origin, in a lithotomy. The blades of the lithotrite could not be approximated without the assistance of a hammer. A small sequestrum had previously been passed per urethram. The characteristic symptoms of stone were present, with an abundance of pus.—*Annales des Maladies des Organes Genito-Urinaires*. (We recall a similar case, seen several years ago, in the practice of C. M. Thomas, Philadelphia.—The patient, who presented the characteristic symptoms of stone, had been the rounds of the Philadelphia surgeons of note, the examinations proving negative. By elevating the buttocks and depressing the handle of the sound, a click was obtained behind the pubic bone. Epicystotomy showed a sequestrum coated with phosphates, attached, but easily detached from the anterior surface of the bladder. Accurate suture, layer by layer; primary union; recovery.—Eds.)

EARLY AMPUTATION IN SENILE GANGRENE.—C. A. Powers (New York) reported, at the last meeting of the Medical Society of the State of New York, a case in which he had amputated through the middle of the femur for arterio-sclerotic gangrene in a man of sixty-seven. The patient died of hypostatic pneumonia, but

the stump showed primary union without areas of malnutrition. The operation was done in accordance with the recommendation of Jonathan Hutchinson, which the author supports, as did those who discussed the paper, as well as the statistics of Heidenhain, based on Küster's cases, that when gangrene has extended from the toes to the sole or dorsum of the foot, amputation above the knee should be immediately practiced. Of course, general contraindications are first to be excluded. A lower amputation is more apt to be followed by gangrene of the flaps.—*New York Medical Journal.*

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

REMOTE RESULTS OF REMOVAL OF THE OVARIES AND TUBES.—Dr. Wm. T. Lusk says (*American Journal of Obstetrics*): The central event is the cessation of the menses. This occurs, according to Glävecke's statistics, in eighty-six per cent. either at once or after a few recurrences of the monthly flow. Of the remainder, in some there is a marked diminution in the amount of the discharge, and in others the continuance is attributable to the incomplete removal of the ovarian tissue or to the peripheral irritation from the ligated endings of the tubes, or finally to pathological conditions of the uterus or of the uterine mucous membrane. As regards the sexual instinct Zweifel's statistics are instructive. In reports obtained from twenty-six cases, no change was observed in ten cases; in three the desire was weakened, in three it was lost; while ten report they had never had any. For those who regard the sexual appetite as compensation for the loss of other feminine functions, it is well to bear in mind that, while in man it is the powerful incentive to exertion, in woman it is in the main subservient to the faculty of reproduction.

Do inflamed and thickened tubes always involve permanent sterility? The following case allows of doubt. The patient, aged 17, suffered agonizing pain at monthly intervals. Examination revealed occlusion of the lower vagina. An opening was made and the retained blood and clots removed. For a long time thereafter the tubes remained thickened and tender. Some time after the woman called upon the doctor. She had been married a year and was seven months pregnant.

Even when relief has been obtained there are few intelligent women who feel convinced that the same end could not be obtained by more conservative measures. It is incumbent, therefore, on the operator to weigh this question carefully in advance.

Dr. Tait admits the occasional recurrence of suppurating fistulous tracts, of fistulous communications with the bladder and intestines, of hæmorrhages between the folds of the broad ligament, and that pelvic pains are not always relieved by the most carefully executed salpingotomy.

Dr. Lusk believes that the performance of normal ovariectomy for epilepsy and insanity, is to be regarded as hardly better than malpractice.

One of the essential characteristics of *gonorrheal salpingitis* is that the inflammation invades the whole wall of the tube—mucous membrane, muscular layers, and even spreads to the cellular tissue.—Dr. T. B. Robinson in *American Journal of Obstetrics*.

EXTRA-UTERINE PREGNANCY.—Dr. H. T. Byford advises in cases of extra-uterine pregnancy in the early months, destruction of the fetus by electricity and confinement of the patient in bed until abortion has noticeably commenced. If rupture has occurred without serious hæmorrhage, and a well defined hæmatocele be discovered we may put her to bed, diet her, keep her quiet, and wait, being at the same time ready for laparotomy. If profuse repeated hæmorrhages occur, it is safer to operate at once. Development having gone on after the middle of pregnancy, either immediate abdominal section is indicated, or fœticide with operation later. In the ninth month and at term, operate in the interest of the child, unless false labor has occurred. After that operate upon the appearance of the first evidence of sepsis.—*American Journal of Obstetrics.*

SYMPHYSIOTOMY.—Dr. P. G. Spinelli reports twenty-four cases performed antiseptically, twelve performed by O. Morisani at the Obstetrical Clinic at Naples, and twelve by himself, five of them at the Maternity of the Hospital for Incurables and seven in the city, with the result of saving twenty-four mothers and twenty-three children, and sums up with these observations:

1. That by means of symphysiotomy, a fœtus at full term, fully developed, can pass through a pelvis in which the true conjugate measures at least 65 mm.; that is a pelvis of the kind that obstetricians of all countries counsel for and practice embryotomy or the Cæsarian section.

2. That a woman with a pelvis so deformed, can submit with impunity to symphysiotomy, provided that the operation is performed antiseptically and in the limits indicated in the article.—*Annales de Gynécologie*, January, 1892.

POTT'S DISEASE AND PREGNANCY.—Dr. T. H. Myers has collected a number of cases of labor occurring in cured cases of Pott's disease of the lower dorsal, lumbar, or sacral vertebra, and find that in no instance has there been a rekindling of the old disease. The chief danger to the mother lies, therefore, in the malformations produced in the pelvis and abdomen, and in the great strain on a vitality already enfeebled. The doctor gave several cases which showed that in cured cases no injury had been done; neither Barber nor Winckel have ever seen a single case where the tubercular process was rekindled by the traumatism of labor. On the other hand, the cases in which pregnancy complicated active disease of the spine, tell no uncertain tale, and in view of them I should advise the termination of pregnancy, in case the disease were active, at the earliest possible date in almost every case.—*American Journal of Obstetrics*.

ELECTRICITY IN CHRONIC PERI-UTERINE INFLAMMATIONS.—As a rule, with the negative in the vagina, 30m, slowly and gradually attained, with the negative in the uterus not over 30m, with the negative in the bladder not over 20m, should be exhibited. The larger the electrodes, the less disagreeable will be a stronger current.—F. Von Raitz, M.D., in *Archives of Gynecology*.

ASEPTIC SPONGES.—Some experiments conducted by Dr. E. Maylard go to show that close-textured sponges immersed for from twelve to eighteen hours in a 1-40 solution of carbolic acid, were not then rendered aseptic, although this had apparently taken place in regard to open textured sponges. The experiments seemed to prove the inefficiency of solutions of carbolic acid of a strength of 1-40 to sterilize the central part of close-textured sponges. Similar experiments on the other hand was made with a 1-2000 solution of perchloride of mercury, and it was found that by this means the sponges were rendered quite sterile.—*Archives of Gynecology*.

RECTAL INJECTIONS OF EGG ALBUMIN.—As the outcome of several series of experiments, the results of which show a great agreement, Huber gives as his conclusions that egg albumin simply beaten up, is absorbed by the rectum, but only in very small quantities, and consequently a nutrient enema of this kind possesses hardly any value. Where, however, a certain amount of common salt is added (15 grains to each egg, in the present series of experiments), the quantity of albumin absorbed is doubled. Peptonized egg albumin was absorbed in a very slightly greater proportion than that treated with the common salt. Of the albumin thus treated with salt, between sixty and seventy per cent. was absorbed and we therefore have in this mixture an extremely valuable material for nutrient enemata. In no case of Huber were the enemata expelled; nor was albuminuria ever found to occur after their use.—*Archives of Gynecology*.

RESULTS OF VENTRO-FIXATION.—In regard to the results of ventro-fixation, Leopold states that all those complaints which relate to the retroflexion itself always cease, but that on the other hand the nervous hysterical complications do not disappear. In Olshausen's cases these, nevertheless, disappeared gradually, though after a very long time.—Dr. Winter, in *Annals of Gynecology and Pediatrics*.

THE ULTIMATE RESULTS OF LAPAROTOMY FOR DISEASES OF THE UTERINE APPENDAGES. In a discussion upon the above subject at the New York Academy of Medicine, Dr. H. C. Coe stated that indurations around stumps of the broad ligaments were sufficient to cause pain, and intestinal adhesions were of very common occurrence, and these, even if slight, would give rise to pain. The speaker

said that there were large numbers of the subjects of the operation which were by no means permanently benefited, so far as relief from pain was concerned¹.

Dr. C. C. Lee had never even seen a case of epilepsy or hystero-epilepsy, or any of the neurotic affections cured by the removal of the uterine appendages.

Dr. Lusk said that the more he saw of these cases the more he was inclined to insist that it was unnecessary every time a woman had a swollen tube to advocate its removal. He was not absolutely satisfied as to the results of operative procedure. He thought three out of four cases would get well under careful treatment.—*The American Gynecological Journal*, October, 1891.

ICHTHYOL IN THE TREATMENT OF PRURITIS.—Dr. Ravogli states that in many cases of nervous eczema, especially in children, a lotion of the following has given very satisfactory results:

R.	Ammon. sulpho-ichthyolat,	. . . . .	3 ij.
	Aqua rosæ	} aa	3 ss.
	Glycerin		
M.			

—*Archives of Gynecology*.

PROPHYLAXIS OF PUERPERAL FEVER.—Litzman, Crédé and Hiegar all advise against the internal examination during the period of dilatation, unless the indications are very clearly marked, as follows:

1. *In disturbances of the general health*.—*a*. Eclampsia and nephritis; *b*. fever, general debility, bad condition of the pulse.

2. *In local disturbances*.—*a*. Bleeding from the genital tract; *b*. Abnormal increase in the intensity of the pains; *c*. Abnormally long period of dilatation.

4. *Discovery of abnormal conditions at the external examination*.—Delay of the head above the brim in primipara or after the rupture of the membranes in pluripara; *b*. Abnormal extension of the lower uterine segment or complete rupture; *c*. Slow fetal heart-beat; *d*. Faulty position or long delay of the fetus.

In the second stage also, the internal examination should be avoided unless the following conditions appear:

1. *General disturbances*.—*a*. Fever; *b*. Bad condition of the pulse; *c*. Abnormal excitement; *d*. Eclampsia and nephritis.

2. *Local disturbances*.—*a*. Delayed rupture of the membranes; *b*. External hæmorrhage; *c*. Defective pains; *d*. Irregular progress in the labor.

3. *Discovered during external palpation*.—*a*. Abnormal position of the fetus; *b*. Abnormal extension of the lower uterine segment or complete rupture; *c*. Slow fetal heart sounds; *d*. Delay of the head at the brim.

After delivery, only hæmorrhage or fever calls for an examination.—*Veit. Jahrbucher*, Band 232, No. 10.

CURETTING THE UTERUS.—Most of the distress following laparotomy is due to the neglected endometritis and not to "adhesions." Those secondary pyo-salpinx occurring in apparently healthy tubes left after removal of the adnexa of one side, are likewise due to the overlooked endometritis. The persistent backache, the descent and posterior displacement of the uterus so often seen, are due to the uterus remaining enlarged and heavy from endometritis. All of these may be avoided by curetting preliminary to the major operation.—W. R. Prior, M.D., in *The New York Journal of Gynecology and Obstetrics*, February, 1892.

OCCIPITO-POSTERIOR VERTEX PRESENTATION.—If, with the head presenting in the occipito-posterior position and perfect flexion, you find prominent ischial spines, do nothing further, but place the parturient on either the right or left side to further favor rotation. Even without postural treatment rotation will usually occur when perfect flexion is present.—S. Marx, M.D., *American Journal of Obstetrics*, February, 1892.

THE STERILITY OF STOUT PEOPLE.—Dr. Risch considers the cause in the case of the men to be the change in the semen, the spermatazoa being present in small quantities, or else entirely absent. On very fat women menstrual disturbances, uterine and vaginal catarrh and metritis are very often present. Also eczema of the vulva, which gives rise to painful coition.—*The Archives of Gynecology*, February, 1892.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY
CHAS. M. THOMAS, M.D.

DISEASE OF THE BRAIN FOLLOWING A SIMPLE NASAL OPERATION.—The *Journal of Laryngology, Rhinology and Otology* gives an abstract of an account of an unfortunate accident described by Wagner in the *Münchener Medicinische Wochenschrift*. The author performed a galvano-cauterization of the left turbinated body in a patient twenty years of age, on account of headache. There was no special pain and there was no bleeding. The next day the patient had a severe headache, and on the third day there was severe hæmorrhage from both nasal cavities. This was treated first with ice water, then by tamponing the anterior and posterior nares. In the evening the patient became feverish, and Cheyne-Stokes respiration appeared. The tampons were removed, but the temperature did not fall and symptoms of a severe affection of the brain developed. Seven days later death occurred. A post-mortem examination was not allowed. The author concludes that the bleeding could not have been the direct consequence of the operation, because it followed some days afterward, and because parts bled which had not been operated on. He believes that thrombosis of a sinus occurred, which disturbed the circulation in the nose. In some other published cases operative treatment of the middle turbinated body was followed by meningeal disease.

THE GLAND OF THE AQUEOUS HUMOR, CILIARY PROCESSES OR UVEAL TRACT.—Nicati draws the following general conclusions from his investigations: The aqueous humor is secreted by the surface which covers internally the ciliary processes, from the ora serrata to the commencement of the iris. Conducted by the canal of Petit, the openings of the spaces between the ciliary processes and the suspensory ligament, the posterior chamber and the pupil, it is emptied into the anterior chamber, whence it is absorbed by the lymphatic channels of the iris. This secretion is the product of a gland, the uveal gland, composed of an epithelium, a vascular and serous well or spring and a contractile apparatus, which accumulates the blood in the well. There are two kinds of aqueous humor: the ordinary, non-fibrinous variety, and the fibrinous or neuro-paralytic variety. The ordinary, non-fibrinous variety is secreted by the glandular epithelium, which interposes as a barrier to the salts introduced by the blood. It does not diffuse these salts unless the blood contains an inordinate quantity of them. Division of the cervical sympathetic favors this diffusion. The liquid of the anterior chamber is subject to an incessant movement of circulation, which prevents stasis and the deposit of opacities on the posterior surface of the cornea. The fibrinous variety, which is produced when the anterior chamber has been emptied, or the nerves of the cornea have been divided, is secreted by the interstices between the epithelial cells. Physiologically it is a reflex secretion, provoked by a disturbance of equilibrium between the ocular pressure and the blood pressure. The nerves of the deep corneal layers are the peripheral seat of this reflex. The nervous mechanism of the fibrinous secretion consists of a secretory apparatus constantly in a state of tension, situated in the ophthalmic ganglion, and of an inhibitory apparatus situated in the medulla and in the ganglion of Gasser. The reflex or secretion occurs whenever the inhibition is suspended, either automatically by puncture, or directly by division of the trifacial. Irritation of the iris and isolated paralysis of the bloodvessels of the eye hasten and exaggerate the reflex. Two pathological conditions are the result of diseased conditions of this uveal gland—glaucoma and detachment of the retina. Glaucoma is, generally speaking, synonymous with retention of the aqueous humor. This retention in youth produces distension of the channels and spaces in which the aqueous humor circulates, or anterior hydrophthalmia. It provokes, by compression of the retina, venous stasis in this membrane and in the vitreous, that is, œdema of the vitreous and retina, or hydrophthalmia posterior. The progressive anterior detachment of the retina is produced by the aqueous humor flowing through a rupture of the canal of Petit.—*Arch. d' Ophthal.*, xi., 1 and 2.

BRONCHIECTATIC ABSCESS DUE TO THE IMPACTION OF AN O'DWYER'S TUBE.—Dr. G. A. Sutherland, of London, reports the case of a young man, aged 17, upon whom laryngotomy was performed for severe pharyngitis, laryngitis and tracheitis,

accompanied by cough, dyspnoea and profuse mucoid expectoration. Eventually the laryngotomy tube was removed, and intubation of the larynx was employed for the relief of stenosis, which had supervened. During a fit of coughing the string attached to the tube broke, and the tube passed down into the trachea. Efforts were made to remove it, but unsuccessfully. Abscess of the left lung followed, and the left pleural cavity was opened, but no foreign body found. Upon removing the drainage-tube from the operation wound, severe hæmorrhage resulted, and a week later, seven months' after the laryngotomy while he was lying quietly in bed, the bleeding recurred, and proved fatal almost immediately.

A post-mortem examination revealed the left lung small and dark in color. On opening the left bronchus an O'Dwyer's tube (size 3, length two inches and a quarter), was found, the head lying three quarters of an inch below the bifurcation of the trachea, and the body passing down into the bronchus leading to the lower lobe. On passing a finger into the operation wound, it entered directly a large cavity in the lower lobe, and touched at the upper part the inferior extremity of the O'Dwyer's tube. The tube was lying free in the bronchus; and on removal it was seen that the head had eroded through the bronchial walls and was separated from the pulmonary artery by a thin layer of fibrous tissue. The abscess cavity and upper air passages were filled with blood, but the exact site of the hæmorrhage could not be determined.—*The Lancet*, January 23, 1892.

PHONOGRAPH FOR DEAFNESS.—Dr. H. F. Gary, Professor of Diseases of the Eye and Ear in the Southern Homœopathic Medical College, has discovered that the phonograph may be used in the treatment of deafness. It is the massage of those parts of the ear which transmit sound to the brain by the vibrations caused by the phonograph which gives the improvement. These vibrations are given with certain degrees of intensity and frequency, according to the exigencies of the case under treatment.

In bad cases, a series of intensified shocks, at the rate of one to the second, is produced against the membranous tympanum. These shocks originate in the phonograph itself, and are not introduced from any exterior source. Every depression in the wax surface of the phonographic cylinder causes the little transmitting needle in the instrument to strike the diaphragm connected with the phonograph, and to reproduce the same distressing noises which a deaf person continually hears within his brain. The intensity of the noises is regulated by the way that the depressions are made in the cylinder, and the frequency by the number of revolutions per minute given the latter.

A SUGGESTION WITH REGARD TO SPRAYING THE NASAL CAVITIES.—Dr. F. A. Burrall, of New York City, writes: "As an aid to thorough spraying of the nares, I have formulated the following method, which originated from a suggestion made to me by a patient on whose nasal cavity I was using the upward spray: Direct the patient to inhale deeply, and place the tip of the atomizer behind the uvula without touching the posterior pharyngeal wall. Then the patient is to close his lips upon the tube and exhale through the nose. This carries the spray well forward upon the walls of the nasal cavities, and when an oily solution is used, such as the extract of pine needles in benzoïnol, the volume of spray issuing from the nose resembles that of the air from the nostrils on a frosty morning. This process makes the spraying of the posterior and anterior nasal cavities more thorough than can be done by an ordinary application. It is a method worth mentioning, as there may be some physicians to whom the idea has not occurred, and they will find it serviceable."

THE TREATMENT OF OZENA.—Dr. Meijer regards the treatment of ozena by means of nitrate of silver spray as superior to all other means. He first packs the anterior nares with dry cotton for twenty to thirty minutes, to remove crusts and mucus. The tube of a spray apparatus is introduced well into the cleansed nostril, and ten or twelve drops of a 2 per cent. solution of silver are sprayed in, care being taken not to moisten the skin or anterior mucous membrane, which is apt to bring on headache, flow of tears, and other disagreeable symptoms. The strength of solution is increased daily, until at the end of four days a 15 per cent. solution is employed, and at the end of eight days a 25 per cent. solution, which is continued for a week. Now the application is to be made only every second day, and treatment continued until crusts cease to be formed, which will be a matter of a few weeks only, in cases which under old plans of treatment lasted two or three years.—*L'Union Médicale du Canada*.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D., FRANK H. PRITCHARD, M.D.,
AND
E. MELLVILLE HOWARD, M.D.

CALCAREA CARB. IN CHRONIC DIARRHŒA WITH EXOPHTHALMIC GOITRE.—Miss A., æt. 30 years, a chronic invalid, had had diarrhœa for twelve years, since an attack of typhoid fever. She has epigastric pain and soreness at night, with otherwise painless stool day or night; from two to six evacuations in twenty-four hours; sleeps early; lies awake the latter part of the night; her appetite is good; breath foul; has a quick, nervous, excitable manner; has right exophthalmic goitre; there is palpitation of heart and irregular pulse from slight excitement, running from 110 to 115, her usual pulse, to 140 and upward to the uncountable; there are purring murmurs, a heart-beat without rhythm, and abdominal pulsations felt through the clothing; she has a dry, hacking cough from tickling in throat; aggravation when lying down; on rising and when excited the cough is constant. Bell. 3 relieved her of the cough within a week. Calc. 3 and careful diet corrected the diarrhœa. Under calc. 30 the pulse returned to 88 and remained there. The murmurs subsided, the irregular beat became normal, the eyes regained their normal look, and in the course of three months she was out enjoying unusual health.—*N. A. Journ. of Hom.*, March, 1892.

FERRUM METALLICUM IN ENURESIS.—Dr. William Lamb reports the case of Mrs. C., æt. 62. Had, as complication of influenza, in September, 1891, cystitis, which chimaphila \varnothing , two minims every two hours, cured, the sediment of urine clearing up entirely. But, on resuming her household duties, she found that she had no power over her bladder, the urine passing involuntarily during the day and not during the night. In Hahnemann's *Materia Medica Pura*, under ferrum, we have the symptom, "Involuntary emission of urine, especially by day." Ferrum met. 30 was given every four hours. After four doses she was unable to pass water at all; there was neither desire nor secretion. The medicine was then stopped, and in a short time the cure was perfect.—*N. A. Journ. of Hom.*, March, 1892.

CURATIVE EFFECTS OF DROSERA.—Dr. Helen Cox O'Connor reports the case of a boy, æt. 18, who had been suffering for several weeks with indigestion, which in him always seemed to produce a cough. For a few days, in the beginning, he had an influenza. At the time of consultation his face was red, having a muddy look; appetite poor; very thirsty; frontal headache; constipated; cough dry, described as a deep bark that jarred him terribly; worse at night and on motion; it was spasmodic, and came about once an hour. For this state he received spongia 30, and was made decidedly better, but the cough then was worse on first moving in the morning and during the day. Bryonia 30 was now prescribed, and did no good; cough increased by motion and cold food; a watery nasal catarrh, with frontal headache, yellowish expectoration; cough begins at midnight; stops soon after 10 A.M.; he feels cold all the time. Dulcamara was now given without result. Then drosera 200, a dose to be given during a spasm of coughing. In five minutes after the first dose the cough stopped and did not return, and the whole condition was relieved, so that he was practically well the next day.—*N. A. Journ. of Hom.*, March, 1892.

CURATIVE EFFECTS OF SEPIA.—Dr. Helen Cox O'Connor reports the case of a young woman of 18 who had irregular menses during the past year. Now complained of having missed two periods; occasional leucorrhœa, milky and bland; frequent urination during the day, with imperative urging; sensation as if every-

thing would fall out of the vagina, so that she felt obliged, when walking, to adduct the legs; intense bearing down; crop of acne pustules, especially on the chin. Sepia 200 was given, two doses an hour apart, and then sac. lac. Bladder symptoms and the bearing down were relieved the next day. In two days the menses appeared, and the acne gradually disappeared.—*N. A. Journ. of Hom.*, March, 1892.

PRIMULA OBCONICA; INVOLUNTARY PROVINGS.—Dr. Allan G. Sym, writing in the *British Medical Journal*, mentions two cases, one in the face of a gardener, of eczema from handling the primula obconica. A.D. had on hands and forearms a moist eczema, papular and excoriated; severe cracking over joints and fingers as from frost; great itching of the skin. D. H. (his successor), had exactly similar eruption of skin. His hands and arms were worse at night, and the itching was intolerable.

Dr. F. H. Clarke related in the following number of the same journal the following case: A lady frequently consulted him during spring and summer for a papular eczema affecting principally the hands, wrists, and fingers. A few hours after working with the plants (of primula obconica), the skin became red, swollen, and violently itchy, and well-marked papules developed. After four or five days desquamation occurs and recovery. On two of these occasions the eyelids have been similarly affected, due the patient thinks to her rubbing them.

Dr. C. N. Lee records another case. A lady consulted him in the spring. For three years she had been subject to repeated painful attacks of eruption on face and hands resembling eczema. The mucous membranes of the eyes and nose were also affected. The trouble was finally traced to the primula obconica. The onset of the attack was usually at night. She became feverish; hands and face would burn. After a few hours, after intolerable pain and itching, erythema with small papules becoming pustular made its appearance.—*Homœopathic World*, March, 1892.

DR. MACFARLAN'S PROVINGS AND CLINICAL OBSERVATIONS WITH THE HIGH POTENCIES.—*Nux moschata*. It seemed as if the lower limbs were as light as a feather; head felt light, as if he had taken ether; numbness in the seat and down the thighs; flighty at night; chilly and feverish; diarrhœa; small stool; straining.

Nux Vomica 94m.—Passes water more freely; cured the burning on voiding it; relieved a dull, severe pain in the epigastrium; felt as if the stomach was sore. Head became clearer, cured a nervous state and sensation of fainting when asleep; nervousness; disposition to nightmare; produced great sneezing; slight soreness in the throat and watery discharge from the nose; burning, scalding on passing urine; sore patches on mouth and tongue; *coated tongue*; can't use tobacco in any way; bowels costive (previously regular); gaping frequently, just as if a person were sleepy; confined him to bed; made him very sick; aches from the top to back of head and neck, which feels stiff; vomits his breakfast; has to force himself to eat. Frequently relieved the ill-effects of eye-strain, asthenopia, and slight intolerance of light.

Oleander 5c.—Sensation of numbness in upper and lower extremities. Have frequently verified this symptom.

Oralis 1m.—Frequent nose-bleed, not accustomed to this; reading affects her head and type becomes blurred; warm flushes; chilly and nervous; *dragging sensations from hip to groin*; feels as if everything in pelvis would be pressed out; urinates freely; pain in kidney so severe as to cause the prover to be bent to find some relief.

Palladium 20m.—Wakeful until two o'clock in the morning; headache across the top of his head from one ear to the other. Pain in head, just above and behind the tip of the right ear.

Petroleum cm.—Has cured very many cases of chronic eczema; parts seem excoriated; the knees feel tired; fatigued easily; thirsty; urinates frequently, and bowels disposed to be loose; slight, dry, hacking cough.

Phellandrium-Aquat 5c.—Giddy when lying down; nauseated; slight sore throat.

Phosphorus cm.—Cured scintillations of light before the eyes; cured some cases of weakness of sight (asthenopia). The prover is nervous, excitable, tremulous; has pain in the right side of the small of the back; *cramps in the stomach*; vivid dreams; burning pain in the small of the back; burning pain and cramps in stomach; vertigo and feeling of emptiness in the head; mental effort causes fatigue; the *burning in the stomach* extends up to the œsophagus; verified this often; a feel-

ing of constriction; dryness of the fauces; bloated stomach and abdomen; choking; disposition to swallow constantly; pain comes down line of sternum to epigastrium.

Physostigma Ven. cm.—Severe cramps in stomach; disposition to vomit; nausea; bowels very loose and light in color; watery stools, with cramps; attacks of trembling; profuse perspiration, lasting a short time.

Phytolacca Decan. 47m.—Tight, dry cough, attended with pain from middle of sternum through to the back; cough aggravated by lying down; swelling on and around the left ear and side of the face, like erysipelas; scalp sore, painful to touch; chilly every morning; sleepy; bowels costive; skin dry; pain across kidneys; urine red and muddy; joints of lower extremities ache; dull pains across forehead; feels wretched on getting up; ache from shoulder to hip; sharp pains shooting through the ball of the eye on reading or writing; poor rest; appetite good; painful red points on the tongue; great pain down the sides of the hips and thighs, knee and ankle-joints; pain in lower extremities causes her to cry out; it is constant in the right elbow-joint, at intervals down the muscles of the forearm.

Pimpinella Sax. 10m.—Gurgling, frequent rumbling noise in abdomen; no pain; seems like formation of an undue amount of gas, as in dyspeptic cases.

Pir Liquida 5c.—Expectoration constant and profuse, occasionally mixed with blood; gums sore and teeth sensitive; headache and sore scalp, left side of head more affected than the right; dryness and burning at root of nose; burning and tingling about nose; cough and irritation of skin, with disposition to scratch in all provers.

Plantago Maj. 5c.—Profuse sweat toward evening, followed by sleepy feeling; awoke in a fright; passed mucus from bowels, which are disposed to be loose; rumbling in abdomen, flatulency; general weakness; seems as if everything was a burden.

Plantago Minor 11c.—Burning pain across the buttocks; great soreness and throbbing on top of the head, sensitive to touch; eyes weak, not inflamed, vision blurred; bowels constipated; piles; stiff neck, hardly able to turn it; pain in the lower part of abdomen; soreness in wrist-joint (mostly right); little finger of right hand stiff; dry tongue; short breathed; pain in the back near waist; scalding sensation in passing water; stiff wrist, and ends of fingers affected as if sore or sensitive; symptoms developed on second day; she thinks she would choke and perhaps die because of dryness and constriction in throat; spasms of muscles of extremities; suddenly breaks out in great heats; startled, as if frightened for a moment or two; teeth become set or closed, and she cannot open her mouth for a time; pains through her teeth; felt as if she needed air; choking sensation; swallowing is difficult, as if there were no power to force down the bolus; sudden, sharp pain through her head, just above the ears; great soreness; urine very dark in color. Woman: given in water for three days, every two hours; "suffering terribly in her right lower limb, from the knees to the hip-joint, and then around to the back; not constant pain, but it comes quick as lightning, with a zig zag course, sometimes every few seconds, and then perhaps after twenty to thirty minutes; she screams out; it leaves a soreness of the muscles." A physician called in temporarily during her suffering diagnosed sciatica. Woman, aged forty: eyes affected in a way she can't explain, simply does not wish to use them; urine appears like coffee; taking medicine every half hour during the day for a fortnight; seized during night with severe pain, like rheumatism; couldn't bear to touch the middle of arm, it is so sensitive; pain in forehead; heat in hands and head; twisting pain in abdomen, with a desire to move the bowels; she tries, but accomplishes little; piles bad, she can scarcely endure them; not subject to this; her eyes are dim, as if looking through smoke; watering of eyes. Symptoms are given in the language of the provers to convey, if possible, an idea of the spirit of the provings.

Plumb. Acet. 1m (F).—Caused very free, watery movements from the bowels six to eight times a day. I have found this remedy useful in constipation when the stools were hard, dry, and difficult of expulsion and light in color.

Polygonum Hydrop. 45m.—Very sick at stomach; severe aching from her knees to her feet; restless in bed from pain in extremities; wakefulness; no appetite; aching in legs, and sensitiveness; face broken out in pustules; bowels, which were constipated, move regularly; menses (had amenorrhœa) returned, but were scanty and very dark; limbs ache, and chilly, followed by fever in the afternoon.

Psorin. 42m.—Caused eczema, with disposition to crusts behind the ears; bowels

always disposed to be loose, now costive, and cured completely a young child's chronic deafness of a mild type; *eyes watered* and inflamed; her eyes pained so she could scarcely open them; sensitive over the eyebrows, down the nose, and back of the head; she complained mostly of her head. A young child who was *always* pale, sickly, and delicate, and who, every few days, was disposed to very loose bowels, was cured of its diarrhœa in a short time by psorin. Since then it has gained greatly in weight. Have often verified this. It is curative in the diarrhœa of scrofulous children. Appetite much better; she must eat in middle of the night; sharp pain at the right side, opposite tenth rib. More extended provings brought out following observations: caused the nose to discharge freely, and cured a child's purulent otorrhœa; the latter symptom verified often; caused soreness below middle of sternum on pressure; a great deal of flatulency; breathing oppressed; distress in epigastrium; bowels that were regular now constipated; frequently verified; eyes and ears, symptoms as above; slight burning on passing water; pain through right groin; her eczema much better; lids of left eye greatly inflamed; lachrymation; bowels loose; move four or five times a day; nervous; easily startled; pains across the epigastrium, and remain in the spleen, as soreness; severe pain in the head; pain in his ear so great as to confine him to bed four days; auricle much swollen. Cured several chronic cases of otorrhœa in adults. Soreness in jaw, right side, around the ear; could not open his mouth without great pain; could scarcely crowd his fingers between his teeth; tear-sac inflamed; epiphora.

Pulsatilla cm.—Soreness within the chest at site of both nipples; giddiness; increase of mucus from throat; very efficacious in curing old, fistulous openings in lachrymal sac; thick and yellow discharge. Chronic cases: many verifications; pain in his right groin, sharp; would come and go; was very severe; slept none for two nights with it; tears would run down his cheeks because of it; when he eats or drinks anything, it causes *cramps* in pit of stomach; thirst for liquids of all kinds; crampy pains in abdomen, low down.

Ranunculus Acris 10m.—Stopped up in nose, burning in hands and face; eyes very weak, and water very much; 10m. Eyes very itchy; light affects them much; roof of her mouth sore; sensation of lump in her throat; difficult to swallow, as if tonsils were enlarged; legs hurt her very much from knees downward as if they were rheumatic; urine increased in quantity; disposed to pass it often, with symptoms of scalding along urethra; the urinary symptoms are the most prominent and constant.

Rhododendron cm.—*Toothache*; facial neuralgia; all the teeth get loose; snags come away; gums much swollen; Astonishing cure of neuralgia; inferior and superior dental nerves; existing seven weeks; woman in agony; sleepless; first dose relieved her; been well ever since; gums swollen; previous to this was under old-school treatment and had three sound molars removed without relief; stiff neck; gums and teeth sore; pains various parts of body; frequently cured facial neuralgia with sensitive teeth.

Rumex Crisp. 45m.—Caused a constant dry cough to be loose, and although chronic or lasting many months, and the woman disposed to consumption, it was greatly relieved in a week; aching pain from the shoulder-blades all the way down the back to region of the kidneys; helps the cough of consumptive persons wonderfully; repeatedly verified.

Rhus Tox. 105m.—Gives great relief, and often curative in ciliary neuralgia, with severe pains through the eye, and in cheek-bones down the side of the nose over the eye, with intolerance of light.

Abdomen sore below the navel; sensitive calves; inflamed throat; tonsillitis; mouth sore; conjunctivitis; rheumatic pains in muscles and joints; intolerable and uncontrollable itching of the feet and legs (worse at night); constantly rubbing one foot against the other, so itchy; sleeplessness because of itching skin; skin covered with a red, uniform, solid rash; slight conjunctivitis; Rash developed in majority of provers; cured many cases of *scald head* in children; the eruption covering the scalp and extending to the surrounding skin in some cases; curative in some cases of slight discharge from ears; cured permanently many persons who had always been subject to muscular rheumatism; removed chilblains; often verified; not much use in ophthalmia where there is photophobia, but *vice versa*. This remedy, under certain conditions, must be the similar in hives, as well as in scarlet fever.

Sacch. Lact cm.—In the early part of proving, feels very badly; unfit for work; weak; caused dizziness, nausea, and occasional vomiting; after taking the medicine for a week urine became scant and dark; have frequently cured vertigo, nausea,

and nervousness with this remedy; head symptoms somewhat resemble belladonna.

Sap. Soda 2c.—Soda soap 2c. Dull, heavy pain across the eyes and forehead; roughness in the skin; dry tetter; face looks swollen; with purple spots. I think the medicine produced a *boil* on a prover's left shoulder after taking it for a week; cold in her chest; all her joints ache; bottom of both heels ache; right one worse; feeling of tightness at middle of sternum; stiff and aching all over from head to foot; abdomen and chest feel sore and bruised; coughing painful; coughs a good deal; eyes very weak; reading is difficult; cured prover of dyspepsia, and bowels now constipated that were regular. 2c. great soreness in her right kidney; severe pain extending down through her right groin and prevents her walking.

Salvia Off. 5c.—Giddiness; sharp pains at apex of the right lung, going through to the back; feels nauseated in the morning; pains around her waist and stomach; five free movements from her bowels from seven to nine o'clock in morning, then no more; gnawing at pit of stomach; the sensation rises upward toward the throat, and she is forced to take a deep breath to be relieved.

Sambucus Nigra. 45m.—Great swelling; heat and redness in glands of the neck accompanied by soreness; improved defective hearing; restless at night; symptoms of a common cold; eyes inflamed; rapid pulse; dry hot skin; complete loss of appetite; general bruised feeling; tongue sore, and very much coated; feeling of great general soreness, as if beaten; dull, frontal headache; high fever; erysipelas-like redness over the whole left side of the head; swelling of the ear; confined to the bed; vivid, frightening dreams; great soreness in the abdomen; bowels move twice daily; feels very tired; after slight exertion legs feel very weak; thirsty; pain in his abdomen keeps him awake; eating causes nausea.

Sanguinaria 24m.—Soreness down the muscles of his back, on either side of spine; feels it more on breathing deeply; pain shifts about; sores around the margins of the gums; sores in roof of mouth; feels suddenly warm; only lasts a few minutes; sharp frontal headache. Did not make extended provings of this remedy.

Santonine, 10th Decimal Trituration.—Has cured very many cases of scrofulous ophthalmia and pannus in children; cornetitis; great intolerance of light; constant watering of eyes; relieved adults almost as quickly; children cured usually had sore nostrils. Cured several cases of chronic otorrhœa with fistulous opening in mastoid cells; Caused coryza; sneezing at all times, day and night; have usually followed this medicine with sulphur; highly curative in nasal catarrh, of children particularly.

Sarracenia Purp. 2m.—Sharp pain through the right lung to his shoulder-blade, commencing three inches below right nipple, and running directly backward to scapula; light-headed; weak; weakness between the shoulders, and below them; soreness in umbilicus; hungry all the time, even after meals.

Sassafras 5c.—Toothache; pain like a coal of fire on passing water; urine looks as if it had flakes of mucus in it; pain in both tubers ischii, and intense pain in both hip-joints; abdomen appears distended, and considerable eructation.—*Homœopathic Physician*, February and March, 1892.

SOME THERAPEUTIC HINTS IN THE TREATMENT OF HÆMORRHOIDS.—At the close of a paper on the treatment of piles, pockets, and prolapsus ani by electro-vibration, Dr. Edward Blake gives the following therapeutic hints:

Itching is met by *sulphur*.

Crawling, by *teucrium*.

Prickling, by *œsculus*.

Edema, by *apis*, *arsenicum*.

Circumjacent eczema, by *mercurius*.

Tenesmus, by *podophyllin*, *aloes*.

Throbbing, by *belladonna*.

Backache, by *bell*, *sulphur*, *œsculus*.

Bladder reflexes, by *nux vomica*, *pulsatilla*, *capsicum*—*Homœopathic Journal of Obstetrics*, January, 1892.

THE MORE RECENT REMEDIES IN GYNÆCOLOGY.—*Artemisia absinthium*. This remedy is an excellent one in the 1x or 2x dilutions to calm the cerebral irritations and the severe hysterical symptoms that sometimes accompany uterine and ovarian disorders. It will relieve the vertigo, sleeplessness and anxious dreams. In several provers of absinthium the following symptoms were noted: dull occipital head-

ache; fulness in the head; could not collect his thoughts; indifferent to everything about him; did not care to move about; sleepy yet unable to sleep; heaviness, especially in lower limbs and across the back; numbness and twitching of the muscles and extremities, especially the hands and feet. One was very nervous, could not content himself; would lie down, but must rise immediately; felt feverish, hot; throbbing of the arteries in the head and neck; full feeling in the head with giddiness; when sitting up, would feel faint and nauseated; oppression and sensation of weight or lead on the chest and about the stomach; tickling in the throat; slight cough; tingling and feeling as if the tongue was swollen, or, as explained, "too large to move freely in the mouth."

Anhalonium used to excess causes convulsions and tetanus. It acts upon the heart as does cactus, causes great and painful palpitation, with depression of the functions of the pneumogastric nerve. In cardiac palpitation due to uterine and ovarian irritation, or at the change of life, it has proved a useful palliative. It should be used in the 2x or 3x dilutions.

Strophanthus.—A large portion of uterine and ovarian disorders arise from venous congestion or stasis. Violent hæmorrhages are often the result of this venous stasis. *Strophanthus*, when given in five to ten drop doses of the 1x dilution, every hour or two will promptly arrest such hæmorrhages. In frequent and profuse menses, when the heart's action is weak, the pulse weak and irregular, or slow and small, *strophanthus* is fully indicated. So also is sanguinaria, especially for the small slow pulse. *Lilium* and *convallaria* act similarly to *strophanthus*.

Aurum.—Gold is indicated in opposite pathological states of the uterus and ovaries, and to use it successfully the dose of the drug should be approximated to each state. The symptomatic indications are clear. Gold primarily causes a condition of active arterial congestion and hyperæsthesia of the ovaries and contiguous organs engaged in reproduction. It will even cause inflammatory conditions in such organs, with fever and increase of temperature, also hæmorrhages, frequent and profuse menses, and dysmenorrhœa and hyperplasia. In these cases, the 6th trituration is the most appropriate.

The secondary effect of gold is to cause paresis, venous stasis, torpor of the functions, scanty and delaying menses, and sterility. These conditions are usually attended by coldness, lack of animal heat, feeble pulse, cardiac weakness, and anemia of the vital organs. Here the 2x or 3x trituration will in a short time bring about gratifying results.

Simule.—This remedy has been used lately for dysmenorrhœa accompanying salpingitis. The symptoms are violent spasmodic uterine pains, burning pains in the region of the ovaries and tubes, which were swollen and tender to the touch. The dose given was ten drops three times daily, beginning five days before the menses, and every three hours during the menses if painful.—Dr. E. M. Hale in the *Homœopathic Journal of Obstetrics*, January, 1892.

PASSIFLORA INCARNATA.—*Passiflora* has been particularly useful in cases of insomnia of purely nervous origin, especially in cases of debilitating diseases which develop a decided neurasthenia, and in which sleeplessness is a marked and very troublesome symptom. It does no good where the inability to sleep is due to pain or distress of any kind; but we find that the nervous erethism is not controlled by the action of opium, sulphur, or other apparently indicated remedy. The dose varies from ten drops to one drachm of the tincture. The latter dose may be given every hour until the patient sleeps. It acts in some cases in the happiest manner in restoring rhythm of the heart's action when that organ is deranged in its movements by the combined effects of exhaustion and loss of sleep.

Passiflora has also acted curatively in the treatment of the morphia habit.

In the doses already mentioned, it may be used successfully in cases of delirium tremens, tetanus and kindred diseases of the nervous system.—Dr. A. I. Harvey, in the *Trans. of the Maine Hom. Soc.*, vol. v.

APOCYNUM IN DROPSY.—Dr. M. S. Briery reports the case of a lady who applied to him for treatment of rheumatism. She had had hæmorrhages from the lungs, and, on examination, valvular disease of the heart with hypertrophy was found. The heart beat very hard. There was general dropsy. In this case cactus and other remedies did no good whatever. *Apocynum* was then given with improvement which lasted for three years. In another similar case with dropsy, *apocynum* worked well.—*Trans. Maine Hom. Med. Society*, vol. v.



Very Sincerely

J. P. Drake

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ON PHILOSOPHIZING ON THE HOMŒOPATHIC LAW.

BY M. W. VAN DENBURG, A.M., M.D., FORT EDWARD, N. Y.

TO-DAY the Homœopathic profession is represented by practitioners of every nation, language, and religion in the civilized world. If we were to compare the religious sects, beliefs, and tenets held by the entire body of practitioners, under the *natural law of cure*, the process would show many points of difference and not a few of contradiction. While the world is growing wiser and more tolerant in every enlightened country, the amount of partisanship still existing in religious bodies is by no means small. Each arrogates to itself the privilege of declaring that it alone is essentially in the right, or more nearly so than any other religious teaching and belief.

It is impossible to find means of harmonizing even the different sects of the same great school or church, as witness the different Presbyterian and Methodist sects, where both bodies have vainly tried to draw all the members of its own group into a unity.

This by way of statement of facts from the religious side. And the religious belief generally enters, more or less, into all discussions regarding ultimate views of "vital forces," "psychic energy," and similar psychological, metaphysical, "spiritual" questions. On the other hand, the medical side, the adherents to the natural law of cure are remarkably harmonious the world over. Some few there are, as must be the case in any large aggregation of the human family, who will not accord to others the same liberty of views they

claim for themselves in the practical application of the law; but this comes rather from an inborn inability to see that, being human, they are liable to be fallible, and consequently that they, themselves, stand some chance of being not wholly in the right, than from any fault of the law of cure. Such are the high-dilutionists, who will have none but the 30c., 200c., 1000c., etc, *ad infinitum*. Of exactly the same sort of stripe, but in a different color, are the low-dilutionists, who will not see that a cure can be wrought by anything higher than the 3x, and who will use only the tincture, or the first or second decimals in their practice.

A third party of this same stripe, in still another shade, is the single-remedy class. To them, no good can possibly come from alternation.

Not the less so is the habitual alternator, who would not dare to give the single remedy, and who does not believe any practical results can habitually be attained by adhering to any other plan than alternation of remedies.

Now, without doubt, every one of these plans, when pursued according to the natural (Nature's) law of cure, has a good modicum of truth in it. But there are a few—yet only a very few, when compared with the whole number of homœopathic practitioners—who belong exclusively to one or another of these stripes.

It is not characteristic of the great body of homœopathic physicians. They are tolerant, generous, and, to a wonderful degree, harmonious on the question of homœopathic practice.

When has a more harmonious and enthusiastic body of practical men been brought together than met at Atlantic City last year?

What other bodies, drawn together by common interest, are more harmonious than the average State and National meetings of homœopathy?

There seems to be a mutual understanding that the common opponents, uneducation and misinformation, must be met by a solid and enthusiastic phalanx of medical reform, based on a *verifiable law* for the administration of drugs.

It is with such thoughts as these in mind that I would raise my personal protest against the introduction of *any* religious or mystical explanation of the *law of cure*.

These are all right for the individual, if he likes that way of looking at it, but I insist that they should not be printed in a respectable homœopathic journal with any implication that they are in any way part or parcel of homœopathy as such.

Imagine for a moment the result, were a Mahometan, a Buddhist, a Romanist, a Greek, a Quaker, a Presbyterian, an Agnostic, and a New-Churchman to meet to discuss the mystical side of the *Organon*, and each to give his explanation of the *modus operandi* of the law of cure "from the spiritual side!"

Yet it is a fact that representatives from every one of these sects and religions named are at this time represented in the ranks of homœopathic medicine, together with scores and hundreds of sects and beliefs not named.

Homœopathic physicians meet and discuss homœopathy with perfect harmony and grand enthusiasm on all occasions.

This could not be possible were *any* peculiar philosophic or religious tenets to gain a foothold, for one moment, as a recognized or in the *least degree authoritative* statement of the law of cure.

Medicine is, and should remain, *the statement of the verifiable*. Nothing else has place in it.

All that "borders on the misty line that stands between the material and the spiritual," all that "takes us into the antechambers of the *unknown*," is not only "distasteful to the hard, practical common sense of material minds," but is *wholly foreign* to the understanding of the *practical* side of homœopathy.

I do not think the fact can be gainsaid, that the practical side of homœopathy is all we have to do with in carrying out the "first and *only* duty of the physician, namely, *to heal the sick*."

In the giving of drugs for this purpose, in the mechanical relief we may bring through practical surgery, or the mechanical use of drugs, in the aid we may afford by modifying the environment through hygiene, in the possible aid we may afford in a few cases through the mesmeric or psychical-force cure, our "sole and only" duty as physicans is to heal the sick.

Other questions may and do arise, suggested by what we see, what we know, and what we know not. They are no part nor parcel of homœopathy as a system of practice. Whoever writes his views upon the philosophy of healing, the "genuine science" of cure, or any kindred question, has the right to a respectful hearing in a philosophical society.

But the moment we introduce philosophy, or religion, or politics, into the homœopathic camp, that moment discord begins.

Each man is at perfect liberty to give such philosophical explanation as best suits his education, belief, preferences, and prejudices. He has the same latitude in this as he has in politics and in religion.

And he may hold to any known plan of view in these departments without in the least weakening or impugning his efficiency in the sole duty he owes mankind in his chosen profession.

I cannot forbear a quotation from the *Organon* that is more frequently overlooked than it should be, though it is of the very first importance, for it furnishes an explanation that clears away a great amount of misunderstanding:

§ 28. Since this natural law of cure has been *verified* to the world by every pure experiment and genuine experience, and has thus become an established fact, a scientific explanation of ITS MODE OF ACTION is of little importance; I therefore place but slight value upon an attempt at explanation.

If Hahnemann had stopped here, instead of covering page after page with an attempt upon which he says, himself, he "placed but slight value," not only would he have been able to steer clear of "the misty line that stands between the material and the spiritual," but he would have kept out of "the antechambers of the unknown." This latter region is, without doubt, very spacious, and when once entered by an unrestrained imagination, no tongue can tell, no mortal comprehend the boundless nonsense that imagination is capable of compassing. In this limitless void all things are possible, nothing is impossible.

Let us, then, in the interest of harmony and progress, place the same estimate upon scientific and philosophic explanations that Hahnemann did; but let us, as physicians, manifest more consistency than did he, by keeping clear of all excursions into the unverifiable.

ACTION OF CROCUS SATIVUS UPON EARS.

BY ROBERT T. COOPER, M.A., M.D.

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(Prepared for the British Homœopathic Society.)

ON 11th of last April there came to the hospital a girl of 16, a domestic servant, who had had a blow eight years ago, at school, from the fist, upon the left ear, and who had had since a small discharging sinus close to the commencement of helix, and dipping no deeper, apparently, than the cartilage of the auricle. Had had a good deal of treatment for this when it first came, but nothing had,

in any way, influenced it. Along with the discharge from this place, there is very considerable pain in the mastoid process, the pain shooting up the back of the ear, and the worse the discharge the worse the pain. The pain has of late been increasing in violence; it is worst in damp weather, and she complains of tinnitus in the left ear like church bells. Bowels regular; appetite very bad; the catamenia came two years ago, and has been unwell but once since, six months ago.

Prescribed calend. off. θ 7 drops in 6 ounces of water, a drachm thrice daily.

9th May, 1891.—Reports: Place no better, but feeling better in herself; the mastoid pain is gone; she feels sleepy after each dose.

To have same in third decimal, a pilule thrice daily.

23d May, 1891.—The mastoid pain returned with the wet weather, but except for this has felt much better.

To have same in second decimal. Same dose.

6th June.—Much mastoid pain; discharge is less; appetite is very bad.

The impression left upon my mind by this day's interview was a very strong one, that calendula, though it had done good, was now decidedly aggravating the case, and my inference was equally firm that a high dilution of calendula would probably complete the cure. But not being certain of there being a high dilution of calendula in the hospital, and having reason to think a great resemblance existed between the action of the marigold and the saffron, I gave instead two pilules of the third decimal *crocus sat.*

A fortnight afterwards, that is, 20th June, she returned, complaining of being worse than ever. There has been more mastoid pain; her appetite is gone, and feels very nervous; no sign of monthly illness.

Considering this evident medicinal aggravation, I gave a pilule thrice daily of *crocus sat.* in 30th dilution.

On 4th July she returned, saying she had not had any pain at all for the last week; monthly period had returned four days after taking these pilules; she was much less nervous; spirits much better, and the spot ceased discharging soon after beginning with the pilules, and is now quite healed; appetite is much better, and except that her legs feel tired in the morning, and that she then had a nasty taste, she seemed quite well.

To continue same.

18th July.—Medicine lasted only until five days ago, and was

much better up till then; monthly period returned on Saturday (11th July), and ceased on Tuesday (14th); the first day without medicine (had lasted a week on former occasion); appetite and noise in the ear have been worse when medicine ran out; the place has been discharging again, but is quite dry this morning.

To continue.

29th August.—Is very much better; has not had any medicine since Tuesday, and has felt a decided difference without it; the pain returned yesterday, for example, and her appetite, especially that for breakfast, has fallen off; other symptoms much better.

To continue with but one pilule every morning.

12th September, 1891.—Very much better, but has had neuralgia in the lower jaw at night immediately she goes to sleep, lessening in the morning; it keeps her awake; appetite is very good, never remembers it so good at this time of year; no mastoid pain; no tinnitus.

To be without medicine for next fortnight.

26th September, 1891.—In every way quite well; has not in any way felt the want of the medicine; no tinnitus; no discharge from the place; no neuralgia.

To cease attending.

This case I look upon as in every way most important and beautifully illustrative of the action of remedies. Many as have been the aural cases which I have brought before your notice, none were so distinctly illustrative of drug action as this.

Bear in mind there was no single symptom, so far as I knew, that corresponded with *crocus sat.* when this was prescribed. The sole reason for prescribing it was its affinity to *calendula*.

Now, if you look to a foot-note to my paper published in January number of *Monthly Homœopathic Review*, p. 5, you will find the quotation from Culpepper's *English Physician*, that "Marigold strengthen the heart exceedingly, and are very expulsive and little less effectual in small-pox and measles than saffron;" a remark that has afforded "copy" for almost every herbal since then, *i.e.*, 1666.

Besides this, I had had in view, when prescribing, a case, fully reported in papers now publishing on the action of *calendula* in the *Homœopathic World*, where *calendula* gave rise to a symptom as if something were alive in the region of the womb, a symptom precisely like that produced by *crocus sat.*, only more immediately uterine.

It is not a little remarkable that when we come upon the higher

stretches of the action of these drugs, we cannot lose sight of the crude and uncultured workings of our forefathers.

A case like the above cannot but prove suggestive in adding to our curative resources. Take for instance this case:

Emma Hyder, aged 44; married twenty-four years; six children; admitted 5th September, 1891; climaxis taking place; flushings.

For the last year has been very deaf, and had also been deaf six or seven years ago. Then it was thought to be nervous deafness, and soon ceased under treatment.

Symptoms.—Very deaf; throat uncomfortable; tinnitus, which dazes her; worse at monthly period; period scanty, dark-colored; urine high-colored; suffers from neuralgia up the back of the head, around the face, and across the bridge of the nose; has no sense of smell; neuralgia continual, worse at noon and in the evening, with pressure and humming in both ears; a singing and humming; feels languid, faint, and very sleepy; bowels are confined; appetite fair; gets twinges in the rectum as from piles, but no bleeding, worse in damp weather; tympanal membranes natural; hearing R. $\frac{1}{2}$ in. L. barely off contact. No uterine history beyond that of bad confinements with subsequent inflammatory mischief.

Prescribed crocus sat. 3x, 7 drops to 6 oz. water, a teaspoonful thrice daily.

26th September.—Has been very ill all last week with depressed feelings and pain all over head and across the nose. Much better this week than last. At first the medicine seemed to search her very much but eased her head. The first week felt better, the second very bad, and now feels better again. Very languid still; urine high colored; monthly period two weeks over time. Prescribed crocus sat. 30, pil. j. t. d.

24th October.—The morning following upon beginning the pilules, profuse discharge came from the nose and continued all that week, but was less the next week. Still has pain round the back of head and across the nose, sometimes also on vertex, with feeling of pressure in the ears: this sense of pressure is always relieved after taking the pilules but the improvement does not last. The singing and humming has left her completely till to-day when it returned with some ear-ache. On the whole she has been very much better since she took the pilules, and her hearing of conversation is as good as she cares to have it. Watch hearing, R. 1, L. 8.

She still feels sleepy; the sense of smell is better, and she can blow her nose for the first time for seven years—never had an incli-

nation to do so before. The pains in the head do not come at regular hours. Twinges in the rectum gone; last monthly illness was of better color, urine also clearer. Prescribed crocus sat. 200, a pilule every morning.

14th November, 1891.—The first few days was very much better, but after this, pressure on the ears returned with pressure on the chest, which aches, and she feels very sleepy. Head-ache goes on day and night for the last five or six days. Before coming here food used to turn acid and rise, but without headache in her bilious attacks. She hears much better, but this pressure on the ears distresses her and her ears crack on blowing up the tubes. Sense of smell again deficient; forgetful, bowels confined, no twitchings. Hearing, R. 4, L. 8. To remain without medicine.

28th November, 1891.—Pressure across the nose, heavy feeling in the right ear with cracking after a dull heavy ear-ache; throat sore with pains in the head, though head-ache less than last week; aching chest still and sleepy. On 18th, monthly period came as a slight show and very dark. Sense of smell not good and unable to blow her nose again. Hearing seems quite good, R. 35 in., L. 30 in.

Believing that the remedy was still acting in the system and that she had had in fact too many doses of it, I again left her medicineless and on the 12th December, took this note: pressure in both ears and across the nose, worst in the night; hearing very good. Pain in the back of head and neck and in the upper parietal regions; bowels confined, spirits better, yawns a good deal, in afternoon and evening gets ear-ache followed by pressure. To be still without medicine.

2d January, 1892.—Pressure on the ears, clouded feeling and some pain across the nose, but less than before; can't blow nose again, but hearing keeps good and general health is very much better. A drawing pain comes from the corner of the mouth drawing up to ears; at times sense of smell good, at others lost, pains in back of head and neck gone, but sometimes flying pains in head; spirits good; on 19th period came, but very dark. To be still without medicine.

23d January.—Blows nose all right, had a troublesome cough last night for three or four hours. Hearing, R. 40 in., L. 35 in. Crocus sat. 200, one dose.

13th February.—Very much better in every respect, can blow her nose quite well, spirits good, though still varying; still has some cough, with tightness on chest and aching across bridge of nose, and flying pains in the head, also a strangling feeling when going from a

cold to a warm air. No tinnitus whatever and hearing seems perfect. For these few remaining symptoms I gave a dose of crocus sat. 200, four globules, but consider it unnecessary to delay despatching the case for further reports; the cough and sense of strangling in the throat were slight and were due I believe to transitory neuroses. The patient herself considered the treatment had done more for her than anything she had tried, and that a complete cure had been effected.

I find among my notes upon crocus sat., that a lady patient, supposed to be suffering from Addison's disease, to whom some years ago I gave crocus sat. 3d decimal, complained of salivation, with constant discharge into the mouth of phlegm, an increase of existing metrorrhage after each dose and a feeling of numbness and stupefaction about the head and tingling in the hands and arms; her friends would hardly believe it was not cannabis indica I was giving.

The conclusions I wish to deduce from these three observations fall naturally into three divisions: (a) undoubted (b) doubtful and (c) fanciful.

It is, I consider, as undoubted as anything can well be that a great resemblance exists between the action of calendula and of crocus sat. as Culpepper pointed out. Equally undoubted is it that without high dilutions we could not have completed the cure of either case; and in the third instance, that of Addison's Disease, where crocus aggravated, the pity is that a high dilution was not given.

Another undoubted deduction is that ear diseases afford no exception to the rule that the most obstinate diseases are under the sway of the homœopathic remedy if properly handled. Though I had always felt this must be so, it has taken me all these years to prove it, in that most obstinate of symptoms, deafness, and why this is so I have shown in the papers now publishing upon calendula.

Years ago I worked at the diseases of the bladder and at that time brought prominently forward the protophosphate of iron as remedial in diurnal enuresis. Naturally on taking up ear diseases I expected to find some such remedy which would meet a fair number of aural diseases, and which would manifest the looked-for homœopathic aggravation prior to the dispersal of the symptoms. But in point of fact amongst the many cases I have reported of aural disease there have been few if any in which this much to be desired exacerbation occurred prior to relief of the prominent symptoms. Frequently had I thought a drug was beneficially aggravating—if one may so express it—but invariably have I been disappointed.

My experience has been, I am inclined to think, the experience of others; and my explanation is that we have been altogether on the wrong track. We have looked out for a medicine that produced the symptom deafness, regardless altogether of the kind of deafness; a matter that I have entered into at length in the papers on calendula already referred to.

Appeal is often made to statistics in proof of the superiority of our system of medicine; but no mere figures can give the practical physician the confidence in his remedies that comes of meeting with such experiences as the above.

The undoubted facts deducible then from our cases, are that there is a strong similarity between the action of calendula and crocus sativus, that the high dilutions are of real utility in coping with intractable forms of disease, and that in some forms of disease much time and care have often to be expended before we can satisfactorily prove what is the homœopathic treatment.

Now for more doubtful deductions. Amongst crocus' aggravations in our first case, we find a nasty taste in the morning (4th July), loss of appetite (20th June), and while the wave of medicinal aggravation was (presumably) expending itself we find neuralgia of the lower jaw setting in and disappearing of itself. Take this along with the salivation and constant discharge of phlegm into the mouth, and we get symptoms which look extremely like a disturbance of the chorda tympani nerve with the submaxillary ganglion and the submaxillary gland. If so, this will point to another likeness in its action to calendula.

In our second case relief to an old anosmia came after profuse discharge had taken place from the nose; it is a fair inference that the relief to hearing may have come about by a similar effect being exerted upon the muco-periosteal lining of the middle-ear cavity. Thus the sense of pressure upon the ears lessened each time of taking the pilules, from possibly an unperceived draining away *viâ* Eustachian passage.

The inability to blow the nose is of considerable interest from a symptomatic point of view and reminds me forcibly of a remarkable case in which this was the principal symptom treated successfully by the late Dr. David Wilson many years ago with ammonium muriat. 200, the key-note having been obtained, if memory serves, from Bönninghausen.

It may be said that while calendula is of such undoubted use as an external remedy, crocus is seldom or ever so employed. True,

but non-employment does not imply inefficacy, and besides many years ago an allopathic chemist who had had a great deal of experience in prescribing for minor ailments, told me he had never seen anything so efficacious as a healing agent in extensive burns as a saffron ointment, and saffron used in lotions for gonorrhœa he assured me was, in his opinion, unexcelled. Besides, from time to time saffron has been used to correct putridity in sores, and has been used according to Merat and de Lens as an application for scrofulous eyelids, etc.

Now for what we may term fanciful deductions. In Hempel's "*incomparable* (!) *Materia Medica*;" *vide* Preface to Watt's *Repertory* to same, vol. ii., p. 245; we read that "Amatus Lusitanus relates the case of a woman, who after taking saffron for a long time in combination with other remedies, gave birth to two girls having a yellow color. This fact (says Hempel) has a purely physical value in so far as it illustrates the effects of absorption upon the fœtus in uteri. A similar observation was made by Hertolt in the case of a she-dog that was with young, and which was fed on large quantities of saffron for some time previous to casting; not only the alvine evacuations but also the little dogs were tinged with yellow."

So far as my investigations go, *crocus sat.*, if indicated, invariably aggravates, and taking into consideration that it violently aggravated our third case, that of Addison's Disease, and that it has produced a general discoloration more like this affection than any symptom produced by any known drug, I am not overstepping the bounds of prudence in suggesting it as remedial in this affection.

As to Hempel's comments upon the action of *crocus*, these only serve to show that a great student of Hahnemann is not necessarily a great homœopath, and that of the homœopathic application of saffron he knew absolutely nothing.

There are some remedies that almost always aggravate prior to manifesting their beneficial effects, if homœopathically selected; amongst these I would place arsenicum, ferrum, and both calendula and *crocus*; others, as sulphur and calcarea, I have found proceed with improvement without any preliminary disturbance, and it is difficult to account for this, for the aggravation is certainly not due to the irritating nature of the particles of the drug, for it holds good of their high as well as their low dilutions.

Seeing then the way in which *crocus sat.* has acted in one case of morbus Addisonii and that it has discolored the entire skin, I feel entitled to suggest it as possibly a curative in this affection.

It is, I consider, very remarkable that the remedies I have found

most efficacious in the treatment of aural disease; to wit, picric acid, ferrum picricum, hydrastis, calendula, and crocus sat. are all of them remarkable for their yellow coloration in the crude state; this will be readily admitted. But what will not be so readily admitted is that each and all of these have a strong hepatic action; and the probabilities are that all of them are specially applicable for gouty disorders. I refer to this from the feeling, and I admit it is little more at present than a feeling, that the spring crocus, the crocus sat. has a power over gouty symptoms, like to, if not equal to, that of the autumn crocus—the colchicum autumnale. It can at all events do no harm to draw attention to the matter.

In one respect I feel sure we are losers rather than gainers in our mode of preparation of homœopathic drugs. The pure juice of the young leaves and stalks does not always contain the full medicinal powers of the plant. The petals of the corolla, and especially of highly colored corollas, as well as other parts of the flower, have an action of their own. We recognize this idea when we employ the stigmata and stiles of the crocus sativus; the medicinal properties of its stalk and of its corm may be widely different.

In the September number of the HAHNEMANNIAN MONTHLY, p. 668, an extract is given from the *St. Petersburg Medical Wochenschrift*, in which Alexjewski recommends the flowers of the red rose as a remedy for the treatment of chronic diarrhœa. Strangely enough a day or two before reading this paragraph I had placed in my hands by a patient what purported to be an infallible specific for chronic diarrhœa and this was nothing more than an infusion of the petals of the red rose to which ordinary white sugar was added. It would seem therefore to me that the petals of the red rose have a specific relationship to obstinate diarrhœas, quite apart from any properties—so far as we have ascertained them—that reside in the leaves and young stalks. If a difference is obvious in the material preparations of the petals, how much more striking will this difference appear in the dynamized preparations.

Lastly, let me point to the homœopathicity of crocus sat. to fistula of the anus.

In our second case the patient suffered from "*twinges in the rectum as from piles*," and then we get in the proving, "pain in the small of the back in the morning and at night in bed, during motion," "writhing," "creeping," "itching," "long stitch" in the anus, all of which points strongly to anal involvement; which, taken with the fact that a sinus in the concha of the ear ceases discharging under its use, are all significant. In one patient where a chronic

discharge existed in the holes pierced for ear-rings in the lobes of both ears, the crocus sat. in the 30th on two separate occasions caused a disappearance of the discharge.

I had intended to end this paper here but the delay occasioned by having repeated crocus sat. 200, in case No. 2, and the subsequent aggravation enable me to add some remarks.

It is very noticeable the persistence of these symptoms: namely, pressure in the ears, pressure in the chest, sleepy feeling, pain (and pressure) across the bridge of the nose, due I consider to a local stagnation of the fluids; to, in fact, an apoplexy; these are very characteristic of crocus sat. and serve to distinguish it from calendula. This I assert, whether or not the reader agree with me in supposing that the crocus was really acting from the middle of November till the end of December. The tendency of crocus to be followed by pressure in the ears led to my prescribing it in a case of a woman of about sixty-five, who on 16th January, came to the hospital with these symptoms: great fulness in the ears, bursting feeling as if all the blood of the head seemed to rush into the ears, with deafness and tinnitus, and tendency to start in sleep. Crocus sat. 200, one dose was given and on 30th January the report was: head very much better, can hear much better, the music (tinnitus) has gone away, and pains and bursting feelings in the head also gone. Moreover, she no longer wakes with this bursting feeling in the head accompanied by intense physical and mental depression. On 27th February, the same patient gave in a still better report although without medicine in the interval.

The crocus patient's spirits are singularly variable, being either excessively despondent or the reverse; the fluids of the body seem to stagnate in various organs, especially across the bridge of nose, over eyes, and in the ears, his sleep is disturbed with horrid dreams, the heart beats and easily starts him, and he wakes unrefreshed, despondency prevails over hilarity and a discolored, unwashed look of the skin should lead us to think of it.

The experiences of the last few months in every way tend to confirm the idea that a single dose of the indicated remedy is sufficient for the breaking down of the gravity if not for the complete cure of the majority of chronic diseases, *mais nous verrons!* Certain it is that allopathy and low dilution homœopathy will have to alter very widely if they even profess to cure obstinate cases of deafness; at present there is no hope for such sufferers save in the single dose, the high dilution and the sufficient interval.

THE USE OF REPERTORIES—A CRITICISM.

BY FRANK KRAFT, M.D., CLEVELAND.

(Read before the Ohio Homœopathic Medical Society, May 10, 1892.)

I TRUST no one who reads this title will continue to read in the hope of learning how to use repertories. My purpose is to criticize *some* of the methods promulgated by repertory users, and I propose doing so without undue prejudice.

Let us understand what is a repertory. The simplest definition, and one which embodies, also, its legitimate use, is *A Dictionary of Materia Medica*; an arrangement of the words (symptoms) current in the language (*materia medica*) with explanatory marks and instances (clinical uses, etc.).

It was my good fortune, at the beginning of my medical career, to have sat at the feet of a master of homœopathic therapeutics, and to whom I owe in great part, if not in whole, my system of study and teaching of *materia medica*. I refer, gratefully, to James T. Kent, M.D., then of St. Louis, now of Philadelphia. Here, at this eventful and formative period of my medical life (before I had become steeped in the awful crime of being "young and inexperienced"), I attempted to learn the use of the repertory in order to "dig out" intricate cases, chronic cases, long-running and deep-seated cases—cases such as had gone the circuit of all the other first-class doctors, but without success. Pursuant to Dr. Kent's system of teaching, he set us actual copy to follow—gave us letters received in his mail, detailing the symptoms of cases submitted for his prescription, and while supervising, made us do the actual work in order to impress the practical value of a given rule. Of all these students, as I now remember, I alone continued stupid and uninstructable, and to my confusion be it said, I am still at the foot of that repertory class, if not upon the dunce-block.

The very last repertorial problem set me, my room-mate, Dr. C. O. Boyce—an expert in repertory work—and I took to our room, and gave it the closest and most minute attention—outlining and filling in every detail, in order, if possible, to convert my stupid scepticism into belief. Every rule was followed to the letter, so far as we both knew; the symptoms were translated from the chaotic narrative of the letter, arranged in sections and numbered. The quantitative

value of the symptoms and remedies carefully noted. We spent one Saturday evening and almost the whole of one Sunday on the case, and when we cast up the answers, found that *calcarea carb.* had appeared thirty-six times, and the remaining remedies of the *materia medica* tailing along in less and less numerical values until we reached *thuja*, or some other closing letter at the bottom of the alphabet—not now recalled—which showed up with a value of 2 or 3. Now, if there is anything in the mathematical value of symptoms, if there is any value to be attached to the frequency of appearance in a case of any one remedy, and that, I believe is the allegation and the reason for numbering the symptoms and remedies, then *calcarea carb.*, heading the list in such great numerical value, with no immediate numerical competitors in our study as stated, ought to have been the *similimum* to be given without an instant's hesitation. But it was not! When we presented our lesson sheet to the professor on the following Monday evening and pointed to the answer as *calcarea carb.*, he ran his eye over the tabulation, then read the letter, laughed and said the remedy was *thuja*! Being appealed to for his reason, he took from his bookcase Hering's *Condensed*, turned up *thuja*, and showed us that the peculiar urethral discharge mentioned in the letter was a leading characteristic of *thuja* which underlay the whole case. "Well, then," I expostulated, "where is the need of all this labor and these pages of figures, if we, after following every rule to its uttermost detail, fail so utterly, while you, without five minutes' study, pick out the remedy on one or two keynote symptoms?" His answer was: "You must study your *materia medica*, find the 'red string' of the remedies and apply it to your cases. Then you will use the repertory intelligently." That advice I have followed literally, for Dr. Kent, of course, did not intend for me to ignore the repertory; and for the next year or such matter, during my leisure moments, and I had a few, I applied myself to the acquisition of *materia medica* and let the repertory alone.

While associated in the editorial work of the *Medical Advance*, some years ago, there came to our copy-box a paper from the pen of Dr. R. C. Markham, then, and perhaps yet, of Jackson, Mich., on the "Use of Repertories." Constantly on the alert for some system or device whereby to curtail the infinite labor of memorizing our *materia medica*, I followed Dr. Markham with pen, and repertory, and *materia medica*. Here, also, as with Dr. Kent, the symptoms of a case were carefully interpreted, and combined and arranged in numbers. After I had followed the repertorial lesson to its end,

and nearly agreed as to the remedy, Dr. Markham kicked over the whole brimming pail of rich milk by adding that having given the remedy thus plainly indicated, he had advised the gentlemen—or the patient—to drop all his engagements (he had worked too hard), go up into the pine woods and hunt and fish and live out of doors, and forget himself for a month or six weeks, which he did. When he returned to his desk, or his tread-mill, or whatever it was, it was pleasant to note how effectually the repertorially selected remedy, given high, had cured the man of nervous prostration.

Latterly, in fact in the February number of the *Homœopathic Physician*, I find a paper by Dr. Horace P. Holmes, of Omaha, entitled “The Use of Repertories in Finding the Homœopathic Remedy,” which caught my attention, and as Dr. Holmes is always a fine reasoner and a charming writer, I make it my invariable rule to read everything bearing his sign-manual. He gives the rough-and-tumble record of A Case of Sick Headache, as he took the case and as the great majority of physicians would have taken it. Then he applies the repertorial yard-stick, lines up the characteristic symptoms, reduces them to sixteen rubrics, as follows :

1. Headache in the morning.
2. Pain going from vertex to occiput.
3. Shooting pains.
4. Splitting (bursting) sensation in vertex.
5. Great weakness.
6. Aggravation from lying down.
7. “ “ cold.
8. “ “ thinking.
9. “ “ stooping.
10. Ameliorated by hot applications.
11. “ on awakening.
12. “ from eating.
13. “ from sleep.
14. “ by bandaging.
15. “ on wrapping up.
16. “ from bending head backward.

He takes the first rubric, “Headache in the morning,” and finds that this occurs under 125 remedies. The second rubric, “Pain going from vertex to occiput,” is found under 3 remedies. The third rubric, “Shooting pains,” occurs under 55 remedies ; and so he proceeds with each of the 16 rubrics. At the summing up he finds *Silicea* has appeared 12 times ; *Nux vomica*, 10 ; *Calcarea*

carb., 8; and Sepia, 8. Therefore, Silicea, being numerically the highest, must be awarded the place of honor in the cure of this headache. Had he shown his confidence in his work, and given Silicea in any form or potency that would have pleased him best, and said, "My patient is now free of these distressing headaches," then the end would have justified the means; but he doesn't. He makes this statement: "This examination showed Silicea so far ahead that on further studying the materia medica I became convinced that I had found the right remedy. At the next visit of my patient I questioned him further, with the view of confirming or not the indication of Silicea. The following additional symptoms of the remedy were brought out in confirmation of the correctness of the work. Intense religious emotion on listening to deep sermons or lectures brings on the headaches. There is often a vertigo with a whirling sensation; has had falling to the right or forward. Has FETID FOOT-SWEAT; must wash the feet every day in summer to keep the feet from smelling foul. Blisters on the little toes and between the toes when on the feet much. Trembling and weakness of the legs; it makes him nervous. Profuse axillary sweat drops away, bad smelling. There was now no doubt in my mind as to the remedy, and I gave him Silicea 1000th, two doses," etc.

This statement, just quoted, knocked the whole fabric of the cunningly devised repertorial structure into inextricable confusion. For, if any member of any class before whom I have lectured on silicea, should know so little of silicea as to fail to learn in five minutes after beginning the examination that the patient was a silicea patient *with* the footsweat, foul or suppressed, I would regard my work as very poorly done. In short, proper examination of that *patient* (which, as Hahnemann advises, and as Dr. Holmes quotes at full in the beginning of his paper, as being the most difficult part of a physician's labor), and not of his sick headache, would have disclosed this unmistakable silicea rubric, and the doctor need not have gone through the intricacies of a repertorial investigation, occupying time and patience, before reaching the remedy.

Naturally to me, a knowledge of materia medica embodies all the good there is in homœopathy, if not of medicine itself. Each of us has his own peculiar and characteristic crankiness, materia medica is mine. In Cleveland, I am pointed out on the street to innocent little children as a confirmed symptomatologist. But I will leave it to this audience whether in each of the cited cases, the mathematical repertory work was not wholly unnecessary? Would not in

each case (certainly in the first and last) a proper understanding of the *materia medica*—and when I say that I *don't* mean the infinite refinements and shadings, and ramifications of the higher metaphysical knowledge of the remedies, but the absolute essentialities, that which every homœopathic school boy knows when he has heard one lecture on each remedy—would not the most ordinary knowledge of the homœopathic key-notes have made the correct prescription?

Is there then no need for repertories? There is, just as there is for a dictionary, and I contend, in this sense mainly, the dictionary cannot take the place of a knowledge of the language; when we refer to Webster, we do so with a word or a sentence in our mind to verify, to correct, or more properly understand; so that the dictionary, while it contains every word in the language, is yet a sealed book unless we fairly understand the language. When we go to the repertory, it is for the purpose of having suggested to our minds some addition or correction, or change, or other modification of the symptom we are running down; but it can never take the place of a knowledge of the *materia medica* itself. In the three cases cited no knowledge of the *materia medica* is assumed. Each case contained thus and so many symptoms, each such symptom is found under thus and so many remedies, and with a numerical value clearly defined. And that remedy which in the summing up has the longest pole knocks the persimmons. A girl of 7 is quite as competent to prescribe on such a system as the sage of 70.

I have in my library a copy, I think, of every repertory in the market. I have studied them honestly. I have spoken with doctors who use them daily. I am always assured that the proper use of a repertory abridges the labor of prescribing, to say nothing of the greater certainty of the selection of the right remedy; but so far, and despite my efforts, I have not yet found any substitute for a careful, rigid and understanding study of *materia medica*.

Prof. Timothy Field Allen, whose indefatigable labors have given us so many excellent homœopathic books, in speaking at the International Congress last year on Repertories, referring to his own recently completed edition of the Bönninghausen *Pocket-Book*, said that the use of it was mainly to suggest a line of remedies—or to cast the symptom within the range of a few remedies—thus narrowing down our studying and overhauling the whole *materia medica* to a half-dozen or a dozen, more or less, of remedies; then by a species of mental cancellation and exclusion as he ran his eye along the line of remedies, he would very soon find the one or the few which may fit

his case. But this also presupposes a good knowledge of *materia medica*.

So that I am fain to conclude that either I am wretchedly stupid in understanding and applying the beauties of the mechanical and mathematical repertory system; or else the proper solution of the sick problem is, as to me, the good old-fashioned way of carrying around with me as much practical *materia medica* as my limited (mental) means will permit.

THE TREATMENT OF PROSTATIC CALCULI AND CYSTIC SEDIMENTARY DEPOSITS.

BY W. E. BESSEY, M.D., C.M., TORONTO, CANADA, AND D. S. OLIPHANT, M.D.,
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THE possibility of curing or removing prostatic, cystic or renal calculi by medical agents, thus avoiding the necessity of resorting to formidable and critical operations, is now a well established fact, but like the cure of cataract by Compton Burnett, of England, or Dr. Med. Schussler, of Oldenburg, Germany, it is so opposite to the teachings and beliefs of the schools and the preconceived opinions of the profession on the subject, that to announce such a proposition is at once to excite the ridicule or derision of those who without any special knowledge of the pros and cons of the subject and without any experience in the matter, are ready, on the strength of old-fashioned teachings, and medical dogmas, to condemn every such undertaking as an absurdity.

At the risk of thus making myself appear, perhaps, ridiculous to the minds of the "blind followers of the blind" in our profession, I will here make the assertion that as certainly as cataract has been made to disappear from the eye of the aged by the use of remedies or medicinal agents, so also has a preparation been discovered (by a homœopathic physician) which when properly administered is capable of removing sedimentary deposits, gravel and stone, from the bladder, kidneys or prostate of the male subject who may unfortunately have been afflicted thereby—and as cystic and renal calculi may be of varied chemical constituents and prostatic calculi of still another chemical formation it is self-evident that the agent in question does not and could not possibly do its beneficent work by any

chemical reaction upon the various elements of which calculi are composed, but upon the agglutinary elements entering into the composition of all alike, whereby the the various particles are caused to adhere to each other and are held in combination. In other words, the cement which has been the active adhesive agent in the formation of the various forms of calculi is amenable to, and capable of, being acted on by the remedy which my medical friend has been able to discover.

That this is a clinical fact he has been amply able to prove during a number of years of critical observation, while his son (who is also an M.D.) has fully corroborated the experience of his father in every particular, and I, who through courtesy have been informed of the facts, and furnished with the remedy, can also speak positively of its efficacy in curing an obstinate case of gravel in the aged.

As to the chemical nature of the various forms of calculi, a few words will be in place just here. Indeed there are few medical subjects involved in more obscurity than the nature and origin of calculous diseases, and none of more interest to the surgeon, and none more difficult to heal. "Renal and vesical calculi," says Mastin, "have from the earliest history of our profession offered a fertile field for pathological research, and those minute concretions which form within the follicles of the prostate gland, although differing in their chemical constituents and manner of formation from urinary calculi, have proved especially interesting, since their true cause has, as yet, not been thoroughly understood. These minute concretions being at first almost microscopic in size, gradually increase, yet rarely acquire any considerable dimensions, seldom becoming larger than an ordinary pea. Still, they aggregate in considerable numbers, studding the follicles of the glands, or when increasing in size they break down its parenchyma and collect in distinct cysts. They are supposed to increase in size from concretions upon their surfaces, and, unless escaping from the follicles (as they sometimes do), produce absorption of the intervening tissue by direct pressure; thus considerable numbers are found collected together, in direct contact, in one or more distinct pouches. Generally, several separate small calculi are found located in separate ducts; these seldom give any trouble, are quiescent and may not give any evidence of their presence, but they frequently escape along their ducts into the urethra and may find their way into the bladder, or be expelled by the urine.

A much more serious condition is sometimes found consisting of a collection of numerous growing concretions in a cyst; these increase in size and may attain quite large dimensions, and set up great irritation and local inflammation, with severe constitutional disturbance, suppurative abscess, or ulcerative burrowing in the soft tissues of the perinæum, until by lancing the contents are discharged through the rectum or outward through the perinæum. It has been conjectured that possibly when prostatic calculi find their way into the bladder they may become the nuclei of true urinary calculi; this is not borne out by observation, for prostatic calculi, being phosphate of lime, we should—if this suggestion were true—find cystic calculi, having a phosphatic nucleus encrusted with the lithates or urates—this we seldom or never do. As to the causes which produce prostatic concretions it is now pretty well understood that instead of being sedimentary, as in cystic calculi—or a deposit of earthy matter in a cavity, as in renal calculi—the deposition of their earthy matter is the result of “a deranged action of the mucous membrane—not a consequence of absolute disease—but the result of a derangement in the secretory functions of the gland itself” (Mastin); or, “a consequence of the dissolution of the elements of the prostate, furnishing a fluid which by gradual formation of deposits produces these amyloid bodies, bodies closely analogous to the Corpora Amylacæ of the nervous system” (Virchow).

The view most generally accepted with regard to the formation of these small calcareous bodies in the prostate is that “they have their origin in an oval vesicle, of a single wall of homogeneous membrane, which is occupied by a colorless, finely-mottled substance, in the centre of which a nuclear corpuscle occurs. They gradually increase in size from $\frac{1}{1000}$ of an inch to $\frac{1}{200}$, or more, by continuous concentric layers; like so many repetitions of the original envelope—the intervals between the layers being occupied by a finely-mottled, deep yellow or red substance. In their interior is a central cavity which corresponds to their external contour in form. There are numerous variations in form which make them occupy an intermediate position between inorganic concretions and organic growths. They simulate inorganic substances in their shape, in their tendency to become infiltrated with earthy matter, and in their disposition to pass to the condition of a dead amorphous mass of a deep yellow or almost black substance. But, like organic growths, they are vesicular in their origin, and their gradual growth, which seems to take place chiefly from the dilatation of the vesicle and successive deposition in its interior” (Mastin).

"Their chemical composition," says Virchow, "is so widely different from that of true urinary calculi (being chiefly phosphate of lime, a substance which is never deposited in an unmixed state from the urine) it is evident that we can always readily distinguish them from those of urinary origin."

"Their chemical composition varies remarkably in the various stages of their development, and is at all times widely different from either renal or vesical calculi" (Barker).

"At first they consist," says Lassaigne, "of little less than animal matter, gradually acquiring calcareous salts when in a state of degeneration." They contain in 100 parts :

Basic phosphate of lime,	84.5
Carbonate of lime,	0.5
Animal matter,	15.0
	<hr/>
	100.

"Vesical calculi, on the other hand, have a distinct nuclei upon which submorphous structures (crystalline and amorphous deposits) settle and become embodied together in a colloid matrix, thus forming calculous masses" (Dr. Vandyke Carter).

According to Mastin and others, when we come to examine the chemical constituents of different collections of renal and vesical calculi, three-fifths of all calculi met with in adults of all ages, are composed of uric acid or the urates; less than two-fifths are phosphates, while only about 4 per cent. of the whole number are oxalate of lime; *but all are held together by the same colloid matrix.* (Note this.)

Three-fifths are the product of urine abounding in an acid of which they are the expression. Two-fifths are the product of urine (generally alkaline, mostly ammoniacal), of which they are the result, ammonia, magnes-phosphates. It follows that the urates, the oxalates, and a few of the phosphates (those formed within the kidney) are the result of constitutional derangements, while the mixed phosphates are produced solely within the bladder and are a consequence of local disease only, and are found present in men with enlarged prostate, who have passed the prime of life; a steadily progressive result or sequence of disease, pathological changes incident to advanced life, which favors the formation of phosphatic deposits within the bladder. When the outlet of the bladder is obstructed and the urine retained, it rapidly passes into a state of decomposition and eliminates free ammonia, which lights up a cystitis. Alkaline

pus is now secreted in abundance, which freely gives up its soda to the phos. acid of the acid phosphates of ammonia and magnesia, which were held in solution only because of an excess of phosphoric acid, and are now precipitated as insoluble phosphates. Now note what follows :

Martin says : "When the pus is changed by the action of the liberated ammonia, it is, with the mucus of the bladder, converted into an *adhesive colloid medium*, which cements together the insoluble ammoniaco-magnesium-phosphates into a mass, and thus are formed the ordinary phosphatic concretions formed in the bladder."

According to Dr. Golding Brown, calculi of the prostate are composed (like other concretions on mucous membrane) of phosphate of lime, mixed with triple phosphate, and may be deposited either in the dilated urethral canal of an enlarged prostate, or in the ducts and cells of the glands, or in both.

The symptoms produced are at first irritation at the neck of the bladder and difficulty of micturition, as in other cases of enlarged prostate ; the calculi may be felt by the finger in the rectum, or with the sound in the urethra. Keeping the urethra well dilated favors their escape, and occasionally one may be removed by the forceps, and it has been recommended to remove them by cutting down upon them from the perinæum (which has been done successfully), but I have a less formidable, and I think a better plan of treatment to recommend, viz., the use of a remedy which acts as a solvent for the calculus.

Now, as all calculi—no matter what their chemical constituents may be or where situated—are held together by the same "*adhesive colloid medium*," it must follow, as a natural sequence, that any substance or remedy that will act upon this adhesive element, or cement and dissolve it effectually, or disintegrate it, thus allowing the particles, of which the stone had originally been composed, to be carried out by the urine, as in the case of gravel, must be a useful and essential element in the treatment of stone, no matter where located, and infinitely to be preferred to the operations of cutting or crushing (lithotomy or lithotripsy) with all their attendant evils.

That such a remedy has been discovered I am glad to believe, although my own experience with it has as yet been comparatively limited.

It is an anti-lithate, or solvent for calculus, wherever found, and is the result of the study and experiments of a most scholarly member of the medical profession of Toronto, now 76 years of age, and

its virtues have been tested by himself and his son, quietly, for years; and his expression regarding it is, that "it never disappoints," and I accept his statement. As to its chemical composition I know nothing. I only know of its therapeutic effects. That it is a most valuable therapeutic remedy in all forms of calculus or threatening calculus when symptoms of gravel are present, I am more than satisfied, and would advise the members of the profession to test it honestly in suitable cases.

The discoverer, Dr. D. S. Oliphant of Toronto, retains the formula for the present for further tests and improvements. He designates it O. H. I have therefore concluded to call it "Oliphant's Anti-lithate" for want of a more perfect or correct title; perhaps some one will hit upon one better adapted to express its true characteristics. I trust that the vast importance of the subject (many of the most vital points of which have not been touched upon at all), will be my justification for bringing this subject, with the new method of cure, to the attention of the profession, and shall be fully rewarded for the trouble I have had in connection therewith, if any practitioner will thereby be aided in his efforts to relieve this most miserable and distressing of affections in old men.

THE HISTORY OF DR. D. S. OLIPHANT'S FORMULA.

The history of my discovery is in brief as follows:

In August, 1882, I was called to attend Captain Winans, an English gentleman who was suffering from ulceration of the stomach, mainly in the vicinity of the pylorus. In the course of my examination of the case, I drew from him a long history of his previous suffering from gravel and stone, and that he was two years previously about to be operated upon by Drs. Hodder and Lizars for the removal of two large stones by the knife; but that when already placed on the table in the usual position for supra-pubic lithotomy, he suddenly changed his mind and told his surgeons they might go home again for he meant to die a "whole man." He accordingly paid them their fee and dismissed them. Soon after he left Toronto for the White and Blue Sulphur Springs in Virginia by way of New York City.

By advice of a friend in New York he took with him a dozen bottles of the genuine Haarlem Oil, manufactured by C. de Koning Tilley, Haarlem, Holland. This firm have only one agent on the Continent, a hardware house in New York. There are several imitations on the market, very cheap and useless. As a result he came home

from the Blue Sulphur Springs free from pain, urinated freely, and meeting Dr. Lizars one day told him of his cure and challenged an examination. Both Dr. Lizars and Dr. Hodder made thorough search of the bladder and agreed that neither stone or gravel existed. One thing is certain, neither of these eminent surgeons was ever known to perform an operation for stone afterward. My patient, the Captain, made one fatal mistake. He was in such terror of a return of the disease that he continued the full dose (25 or 30 drops) of the nauseous drug, nearly every day, until fatal ulceration commenced, and he, shortly after my unfavorable prognosis, fell into the hands of a popular member of the old school faculty, who was confident allopathy alone was capable of saving him; ten days finished him and the worthy surgeon declared he was called in *too late*.

I saw clear and unmistakable evidence of the power of this compound to dissolve the concretions of urates and lithates, but the drug was so severe an irritant of the mucous coat of the stomach that it was not safe to use in so large and continuous doses. Could it be made successful as an attenuation?

For six months I experimented in every way to find *a solvent* that would hold the drug in complete solution, and that would be harmless and also make a permanent solution at any temperature and uninfluenced by light. One night I retired at a late hour after unusual fatigue in making search for the desired solvent, and as I was opening my book to have my customary luxury of a good "read" the idea came into my head, "why have you never tried chloroform as a primary solvent and reduce further with pure spirits?" I leaped from bed and ran down to my surgery and was delighted to find that chloroform made a perfect *solution* of the entire drug, but that the addition of alcohol (96 per cent.) could only be made to a certain proportion without precipitation. I went to bed satisfied I had the key to the problem, and after a year's variable experiment, I have arrived at the following:

FORMULA.

To make 16 oz. of *solution* of O.H. $\frac{1}{10}$ (Haarlem Oil.)

Requires a well glass-stopped 16 oz. bottle.

Two bottles *Tilley's* Haarlem oil.

Chloroform D. and F. V.s. for solution.

Alcohol q.s. to make 16 oz.

Application *continuous* of say 98° to 100° of uniform heat, till permanent solution is obtained (usually forty-eight hours).

THE PROCESS.

1. Put two bottles of Haarlem oil in the 16 oz. glass-stop bottle.
2. Add $\mathfrak{z}\text{ii}$. fl. of chloroform and shake well.
3. Add alcohol ounce by ounce, shaking well till precipitation is shown by want of clearness.
4. Add chloroform $\mathfrak{z}\text{i}$. by $\mathfrak{z}\text{i}$. agitating till clear.
5. Add alcohol and chloroform by turn as before till two-thirds full. Then fill with alcohol and finish by subjecting the bottle and its contents to the constant heat of 98° to 100° , stopper loosely applied until *quite clear*. Test the effect of cooling and renew the heat if necessary for forty-eight hours till it remains permanently clear in any temperature.

Dose: 6 to 8 drops on sugar two or three times daily, after meals.

N. B.—Let the medicine be prepared *before* meals to allow evaporation of the alcohol.

THE ATHLETIC LUNG.

BY T. C. DUNCAN, M.D., CHICAGO.

THE article by Dr. W. C. Goodno, in the November, 1890, issue of HAHNEMANNIAN MONTHLY, is a timely warning as to the bad effects of strain to which athletes subject themselves.

The well-known fact that a large percentage of athletes die of phthisis, should act as a check to the excessive strain to which athletic training is carried to-day. The well-known athletic Professor Dowd boasts of a lung-expansion of eleven (11) inches, and I do not doubt it with his wonderful muscular development. I have met, as medical examiner for life insurance (Royal Arcanum, National Union, etc.) two men who, on forced inhalation, expanded nine (9) inches. For a musical council (N. U.) I examined several men who could expand eight (8) inches. As the normal expansion is only about four (4) inches, this forced dilatation must produce extra strain on the alveolæ of the lungs, and taxing the lymphatic system to take care of the extra lymph, and so bring about the true pathology of phthisis (hypertrophy, infiltration, and degeneration of these glands) when the excessive strain is intermitted and finally removed.

High altitudes tend to produce athletic lungs, and doubtless cures thereby.

The feeling produced, as I experienced in New Mexico, at an altitude of 7000 feet, is very similar to that induced by running. I was something of a sprinter when young, and the panting respiration in a high altitude, upon any active exertion, recalled the familiar condition. The effect upon Spaulding's base-ball team of a winter's training at Deming, N. M. (4400 feet up) I shall watch with deep interest.

Physicians should know more of the effects of athleticism, and be able to give sensible advice. A professor of physical culture in a ladies' school ordered off the under-skirts of a young lady patient of mine of a consumptive bias. She took cold, had to leave school, and has gone to a southern latitude to recruit. She has no cough, but the lymphatic (blood) glands are shocked off duty, and she is in the prodromal state.

Have we not a hint where to send persons who suffer from lung strain, and especially athletes who begin to fail? They should go to a high warm or cool region, and, as they improve, gradually return to a lower altitude—if they must. But, it is a question if it would not be best for these people, who have produced artificial and extra dilatation of the lungs, to remain in a high altitude. May we not naturally look for lung disease in college-bred athletes, when they enter office-life in cities where there is a large amount of moisture in the air?

One of the most momentous questions that confront the profession to-day, is to ascertain the causes and prevention of tuberculosis in this country; especially is this a vital question in the New England States, where twenty-five (25) per cent. of the total deaths are from consumption.

In all the States east and north of Pennsylvania the mortality from this disease has reached twenty (20) per cent., and is steadily increasing.

In isolated valleys in New England the number is far in excess of these figures. Non-expansion is undoubtedly more frequently a cause of phthisis pulmonum than forced expansion of the lungs. Evidently, lung gymnastics should receive more attention.

ACETIC ACID IN MEMBRANOUS CROUP.—Dr. A. I. Harvey says that acetic acid from the θ to the 3x is capable of saving cases of this disease when other remedies have utterly failed.—*Trans. Maine Hom. Soc.*, vol. v.

REPORT OF SIX MONTHS' SURGICAL WORK AT THE HAHNEMANN
COLLEGE HOSPITAL, PHILADELPHIA.

BY CARL V. VISCHER, M.D., PHILADELPHIA.

(Read before the Philadelphia County Medical Society, March 10, 1892.)

THROUGH the courtesy of my chief, Professor John E. James, I am enabled to present the following report of the surgical clinics and the work done at the Hahnemann College Hospital during the winter session of 1891 and 1892. I desire to preface my remarks with the methods employed, in order that comparisons may be made between others than those practiced.

The aim has been, wherever practical, to pursue aseptic surgery, and only in those instances where this was impossible was resource had to the antiseptic method. In carrying out the aseptic principle it is taken for granted that the part is either in an aseptic condition or is made to be such prior to any operative interference. Therefore the greatest possible care was exercised in the preparation of the operating theatre and instruments, as well as everything that came or could possibly come in contact with the field of operation. The clinic-room was constantly kept scrupulously clean, not by means of disinfectants, but by thorough scrubblings at frequently repeated intervals; all necessary furniture was constructed in as simple a manner as possible, having no corners or crevices in which dirt could easily accumulate. To best comply with these ideas, instrument and dressing-tables were of iron piping bronzed, with French glass tops, which were all thoroughly disinfected prior to each clinic. The instruments were thoroughly sterilized by boiling in distilled water containing three per cent. carbonate of soda, in which solution they remained while in use. The silk was sterilized by boiling, and the catgut was prepared according to Kocher's method; silk-worm gut, after being disinfected in bichloride solution, was preserved in alcohol. Sponges were not used. Tampons were all thoroughly sterilized by compressed steam and brought into the clinic in airtight jars. The dressings used were sterilized gauze, cotton, five per cent. iodoform gauze and protective; the latter was disinfected in bichloride of mercury solution and then placed in sterile water prior to using. Drainage tubes of rubber were preserved in carboglycerine solution. Gauze and muslin bandages were also made

sterile by steam, as well as towels, sheets, operating gowns, and all linen that came or could come in contact with the patient. For irrigating, plain sterilized water was employed, no chemical being used after the patient entered the operating-room. The field of operation was prepared several hours before being attacked by thorough scrubbing and shaving, after which a bichloride of mercury compress (1:2000) was placed over it. Previous to operating, the field was again scrubbed with *sapo-viridis*, shaved and rinsed with alcohol and sterile water. This principle was carried out in the after-treatment where possible. Special attention was given the hands of the operator and assistants, experiments having proven these to be not infrequently the cause of infection. For three months, the method advocated by Kelly was employed, viz., after cleansing the hands and nails with soap and water they were soaked for some minutes in a saturated solution of permanganate of potash, which stains them a dark-brown; from here they were bathed in a concentrated solution of oxalic acid, which removes the stain; finally they were rinsed in bichloride of mercury solution (1:1000). Later, preference was given the following method: after thorough scrubbing with soap and hot water for some ten minutes; they were soaked for a few moments in bichloride solution (1:500) and then rinsed with alcohol and water. These methods having been rigidly adhered to, the results obtained, as may be seen from the following report of a few of the more interesting cases, prove all the seemingly trifling details amply repaid for any loss of time or trouble they necessitated. From the 1st of September, 1891, to the 1st of March, 1892, there were 951 cases admitted to the accident ward; of these there were:

	Cases.
Burns,	31
Contusions,	134
Sprains,	59
Luxations,	12
Fractures (12 of which were compound),	93
Contused wounds,	115
Lacerated wounds,	222
Incised wounds,	54
Punctured wounds,	28
Gunshot wounds,	4
Poisoned wounds,	4
Foreign substances in various parts, such as the eye, throat, etc.,	53
Strangulated hernia,	2
Concussion of the brain,	3
Retention of urine,	3

There were 254 cases admitted into the wards. In the clinic the following operations were performed :

	Cases.
Amputation of the breast,	7
Fore-arm,	1
Hand,	2
Foot,	1
Thigh,	1
Supra-pubic cystotomy,	2
Perineal section,	8
Herniotomy,	7
Tenotomy,	7
Osteotomy,	4
Craniotomy (linear),	2
Necrotomy,	4
Urethrotomy,	3
Colotomy,	1
Trephining,	2
Enucleations of tumors,	17
Excision of astragalus,	1
Fistulæ,	9
Hæmorrhoids,	7
Hydrocele,	7
Castration,	3
Paracentesis of abdomen,	1
Paracentesis of tunica vaginalis,	4

Making a total of over a hundred operations performed before the class. I may say, the only complications that arose were a few stitch abscesses, causing in some few instances a rise of temperature, and occasionally, where catgut was employed, it absorbed too rapidly, preventing primary union.

Of nine deaths that occurred, only two can be directly attributed to operation. One was due to peritonitis following herniotomy, probably caused by persistent oozing ; the other following a perineal section in a robust negro for impermeable stricture, who, on the third day after the operation, had a rise of temperature of over 105°, and which continued to remain high for some eight days, at the end of which time he died from prolonged hyper-pyrexia, the cause of which is mysterious, as there were no post-mortem changes that could account for death, save such as are brought about by continued pyrexia. It may be classified among those cases of so-called "urethral fever" about which so much has been written without improving our knowledge as to their nature.

Of the more unusual cases we had to deal with was one of prostatic calculi. J. R., æt. 48, was admitted into the hospital on Janu-

ary 18, 1892, suffering from a tight stricture in the deep urethra, with the usual symptoms accompanying such cases, save the pain about the glans seemed to stand out more prominent than is customary. Rectal examination showed the prostate but little if any enlarged, hard and nodular, so that prostatic stone was suspected prior to the operation. Under ether a filiform was introduced and perineal section done in the ordinary manner, after which on introducing a finger the stones, which varied in size from that of a bean to a hemp seed were easily felt and extracted, save some few which were very adherent to the tissue. Some fifty-eight calculi were removed when it was found that the greater portion of the gland had been absorbed and replaced by the stones; therefore one of those rare instances where little of the prostate remains, its place being taken by a sac of calculi. Recovery was prompt and uneventful excepting that for the first few times some little difficulty was experienced in passing a sound, the beak of which was prone to catch in the prostatic sac.

CASE II.—E. S., æt. 76, entered the hospital on the evening of November 13, 1891, suffering from retention of urine for the past thirty-six hours, repeated attempts at cathertization by his physicians failed. Introduction of a catheter again proving futile and his condition demanding prompt relief as the bladder was much distended, a hot sitz bath was given, during which a silver catheter was introduced with but little difficulty. Here was a man suffering more or less constantly from retention, and it was quite evident that unless permanent relief could be given life would be but short. Examination of the prostate showing it to be but moderately enlarged; the sound, however, detected a protuberance, consequently an enlargement of the so-called "third lobe" was diagnosed, which acted as a valve to the escape of urine. Supra-pubic cystotomy was advised and subsequently performed, when as suspected a lobe as large as the distal phalanx of the little finger was found directly in front of the urethral orifice; it being pedunculated its removal was undertaken in preference to the establishment of a supra-pubic fistula. The hæmorrhage following its evulsion was but slight and unimportant. The operation was borne well and followed by but slight reaction, the ether however gave rise to an obstinate bronchial catarrh which succeeded in prostrating the patient excessively; this together with the fact that vitality was at a low ebb made the prognosis bad. However the man rallied and did well for several days when a change to the opposite set in and he gradually sank, dying some sixteen days after the operation of asthenia.

CASE III.—Mrs. S., æt. 81, was admitted into the hospital on November 23, 1891, suffering from a suppurative synovitis of the right knee, from the drain of which she was rapidly becoming prostrated, so that amputation of the thigh in its lower third was done, from which she rallied nicely, the stump healing in the greater part by first intention. The highest temperature was 99.6 degrees.

CASE IV.—A. T., æt. 60, entered the hospital January 29, 1892, suffering from a large tumor of the left testicle which he first noticed some two years since, but which did not begin to grow rapidly until the past nine months, during which time it arrived at such size as to compel him to support it by a sling passing around the neck. From its rapid growth together with its physical characteristics and frequency of such tumors in those parts it was diagnosed as a soft sarcoma, and its removal insisted upon, which was done by two elliptical incisions including a considerable part of the scrotum. On examination the greater part of the growth was found to consist of fat, the nucleus of which, somewhat larger than a fist, being of firm fibrous tissue and evidently originating from the globus major.

A microscopical examination has as yet not been made, consequently the true nature of the tumor is not known, but in all probability from the microscopical appearance of the nucleus it will prove to be sarcomatous, nevertheless the case is of interest, as sarcomata are of comparative rarity at such an advanced age, and lipomata of the testes are almost pathological curiosities. The patient made a good and uneventful recovery, the wound healing per primam, save the site of the drainage-tube which granulated slowly after its removal on the second day. The highest temperature was 100° the day following the operation.

CASE V.—C. B., æt. 12, admitted into the hospital December 15, 1891, suffering for some two years from apparent vesical irritation, which during the past three months became markedly aggravated, necessitating him to seek relief. The principal symptoms complained of were, uneasiness in the hypogastrium, with increased desire of urination, accompanied by pain and once or twice by some little blood; stone was of course at once suspected, and on the introduction of a searcher the suspicion was confirmed, demonstrating the presence of quite a good sized calculus. Its removal was advised and subsequently accomplished, through the supra-pubic route. The present status of the high operation is so well known that remarks concerning it would be superfluous. In place of draining the bladder through the wound, primary suture was practiced,

there being comparatively but little cystitis, therefore it was believed to be a favorable case for this procedure; however the success was but partial as the cat-gut employed absorbed too quickly allowing part of the wound to gap; aside from this the patient made an uneventful recovery, the wound being completely healed at the end of a month following the operation.

CASE VI.—H. S., æt. 34, was admitted January 17, 1892, suffering from a moderate sized scrotal hernia of the right side, which was impossible to keep replaced by means of a truss and allow the pursuit of his calling; this together with the constant risk of strangulation led him to ask relief through operation, which was done after the method first advocated by Czerny and subsequently modified by Riesel, consisting of tying the sac high up in the canal and removing it, the tissues being coapted by buried sutures of cat-gut excepting the integument which was united with silk. The wound healed throughout by per primam excepting a couple of stitch-abscesses at its lower portion. Recovery therefore was rapid and satisfactory. There yet remain a number of cases possessing considerable interest to report which would require more than the allotted time. In conclusion, I would say, that after a series of bacteriological examinations of the air in the clinic room, we had demonstrated the fact of the presence of considerable numbers of micro-organisms, and principally the yellow and white staphalacoccus, consequently we have been made cognizant of the cause of some failures at primary union, and know in which direction to turn our attention toward correcting this source of infection. The air was examined by exposing a number of gelatin plates during the preparation for the clinic and also at the time of operating.

SANITATION.

BY J. C. CUMMINGS, M.D., ST. LOUIS, MO.

(Read before the Missouri Institute of Homœopathy, St. Louis, Mo., April 12, 1892.)

CAN the practice of medicine be made an exact science? I answer, Yes; when the laws of life become known. We can only learn these laws through the study of sanitary science; and this science includes chemistry, and all that can be learned in the study of vegetable and animal life. Claude Bernard taught "that plants digest

as well as animals, and that the process in both kingdoms of nature is fundamentally the same." I will merely allude to that curious order of plants—insectivorous—and pass at once to that large family of seed-plants which store up albumin, starch, cane-sugar and oil in their seeds; just as albumin and fat are stored up in eggs, and for the same purpose, namely, to sustain life in their young. Sir William Roberts, in his most excellent little work, *Digestion and Diet*, says: "It has long been known that the transformation of starch into sugar in germinating seeds was effected by diastase; and that a similar ferment, existing in saliva and pancreatic juice, performed the same office on the starchy food of animals. It has also been proved that the stores of starch laid up in the tubes of the potato, and in various parts of other plants, are changed at the period of budding and growth in the same way and by the same agent."

I quote this much to show the importance of studying vegetative life. If the digestive process is the same in both, and the digestive ferments are the same in both kingdoms, then it follows, that the vegetable kingdom being less complicated is the best field in which to study the processes of life.

It has been ascertained that "Diastase acts exclusively on starchy substances. Pepsin and trypsin act only on the nitrogenous principles—the emulsive ferment of the pancreas is only capable of acting on fatty bodies, and trypsin converts cane-sugar into fruit or grape-sugar."

It has also been found that when cane-sugar has been injected into the blood of animals, that it passes through the kidneys as cane-sugar. I think I can safely say, from the above facts, that one of the causes of diabetes—if not the only cause—is this lack of trypsin in the small intestines, whose function it is, to convert cane-sugar into grape-sugar. The remedy in this case, is to give the diabetic patient milk digested with trypsin. Dr. Roberts says, "Fat is largely taken up by the lacteals in its unaltered state, except in so far that it is finely divided or emulsified. Grape-sugar (dextrose) is not known to suffer any digestive operation but to be absorbed unchanged. Perhaps it would be more correct to say that grape-sugar is an article of food predigested for us by the agency of plants." Here then is another food for diabetic patients, namely, grapes and grape sugar. We all know how children crave sugar; even horses, dogs, and other domestic animals like sugar.

The little negro children get fat during the grinding season, on

sugar-plantations. Then it follows that sugar is a necessity of animal life.

Dr. Jonathan Hutchinson "forbids his patients who are suffering from gout, the use of sugar or cooked fruits, if eaten with sugar. Cane-sugar he finds particularly injurious." Using plenty of trypsin to convert the cane-sugar into grape-sugar, we need not deny our gouty or diabetic patients the luxury of cane-sugar with oat-meal or cooked fruits. Claude Bernard's, Schiff's and Pavi's experiments, puncturing the fourth ventricle, section of optic thalami, and medulla oblongata, were too violent and radical to be of any scientific use. We might as well extract the pancreatic gland, and expect the animal to thrive afterwards on starchy food. Dr. Raue located the saccharinity of the blood in the *intestines*. But not as he conjectured, "in consequence of an impeded conversion of cane-sugar present in the intestine into lactic acid," but as Claude Bernard and Dr. Roberts proved, a want of trypsin to change cane-sugar into grape-sugar, which can be readily assimilated, and converted into healthy tissue.

In the *Satellite*, September, 1891, Dr. Francois Cartier concludes from experiments with poisonous substances producing sugar in the urine—"that the danger in chronic diabetes lies not in the presence of the glycosuria, but in the presence of toxic substances derived from the sugar." I infer from the paper that these toxic substances, such as "alcohol, diacetic ether, acetone, lactic, acetic, formic," and other acids, are only found in the last stages of diabetes, when the nervous system has been most profoundly impressed.

Not diabetes only, but all diseases, may be prevented by discovering the laws of sanitation, and observing them. A great saving of vital force may be obtained by a large use of animal fats when the digestive forces are below par.

Climate and the seasons have much to do with the kind of food we ought to eat. The Esquimaux require a great excess of fat, while the denizens of the torrid zone crave and need juicy fruits for comfort and health.

Dr. Dobell says, "The food of an adult man, under ordinary circumstances, should evolve 10,000 British units of heat,* in addition to other purposes. Eight thousand British units are required as sensible heat, to raise the temperature of the inspired air to the temperature of the body, and maintain animal heat. Of the remaining 2000

* A *British unit of heat* is the amount of heat required to raise the temperature of one pound of water to one degree Fahrenheit.

British units (equal to 690 foot-tons)* more than half is expended by the heart and other organs of the body, leaving about 290 foot-tons available for external work." Thus we see, nearly all the food we consume goes to maintaining our bodies in good working order. But any excess of food, above that required to keep the bodily organs in their normal condition, and do the external work we are required to do is injurious—because it throws an additional work on the liver and kidneys; or if this excess of food goes into useless adipose tissue, it only causes the muscles to do unnecessary work, or may run into fatty degeneration of the heart, and cause premature death.

Another danger of eating an excess of starchy and fatty foods, out of proportion to the proteid substances, is a lack of oxygen in the system to oxygenize the proteids, which causes an excess of uric acid, instead of urea; and this condition it is thought produces gout and rheumatism.

Dr. Dobell says, "It has been found that the presence of *hydrogen with oxygen, in the proportion to form water, does not affect the total heat of combustion.* It is only the *excess of hydrogen, that can be made serviceable as a source of available heat.*"

Dr. Roberts (*Digestion and Diet*) says, "Henninger succeeded in obtaining peptones in great purity. An analysis of peptones so obtained, indicated that they contained less carbon and nitrogen, and proportionately *more hydrogen* than their original proteids."

Now mark, that it is the excess of hydrogen that causes heat, and in the digestion of proteids hydrogen is set free. The scientific course to pursue in fever is to restore enough oxygen to the system to form water with this excess of hydrogen, or, failing in that effort, at least to take from our *fever* patients proteid foods.

At any rate, we all can see how unscientific it is to give our fever patients meat juices. Dobell says: "*Liebig's extract of meat and other similar preparations contain very little, if any, nourishment, properly so-called.* Their principal virtues belong to the class of stimulants and blood tonics." Fothergill and some others think that many patients have starved to death on beef-tea.

Dr. J. S. Bristowe, speaking of the diet of enteric fever, says: "Dr. Murchison admits, what most of us know by experience, that beef-tea and other animal broths and essences not unfrequently promote diarrhoea in enteric fever; and the suppression of the salivary, and probably of the pancreatic secretion which attends the disease,

* A *foot-pound* is the amount of mechanical force required to raise a pound weight one foot.

interferes importantly with the digestion and assimilation of starchy matters, which thus, as Dr. Cayley especially maintains, become irritants to the alimentary canal." Or, in plainer language, beef-essences not only cause diarrhœa in enteric fever, but interfere with the digestion and assimilation of starchy foods.

The two things I wish especially to call the attention of the members of the Institute to, is the importance of trypsin in intestinal digestion, and the part that an excess of hydrogen plays in causing fever.

Dr. E. O. Shakspeare, in his "Report on Cholera in Europe and India to the U. S. Government," quoting from an article on Bacteriology, says: "The author showed that a simple culture of the cholera bacilli, possessing little or no virulence, when cultivated in a favorable medium where they lead an *anaërobic existence*, for example, albumin of white of egg endows that culture fluid with toxic qualities which it does not acquire, or acquires only after a long time, in the case of cultures in ordinary media under *aërobic* conditions. Thus, a culture forty-eight hours in egg albumin becomes sufficiently toxic to kill two of three guinea-pigs, and to make the third very sick; whilst four weeks of *aërobic* culture in bouillon produces a liquid which has scarcely any virulence."

The plain deduction here is not to eat eggs during a cholera epidemic, and I would say do not give your patients white of eggs in enteric fever, or chronic dysentery, or chronic diarrhœa, for you may develop ptomaines that would cause the death of your patient. Prof. Vaughn, of Michigan University, has described the ptomaines that sometimes are found in cheese and milk.

The lesson taught in this paper is to so live that neither bacilli nor ptomaines can find any foothold in our bodies, and we ought then to escape most, if not all, diseases.

ACTION OF MERCURIUS CORROSIVUS ON THE SKIN.—The following symptoms were noted after a breast excision in which bichloride dressings were freely used. 1. Intense irritation of the skin and diffused redness. 2. Widespread dermatitis, the wound failing to heal by pure intention (though the sublimate dressing was removed the second day.) 3. In the course of the next few days a diffuse erythema spread over the whole body, creeping onwards like blotting paper. In one case the erythema stopped in the middle of the body. In the other case, it spread over the whole body; it continued for three or four weeks. 4. In this case it changed its type, scattered, urticarial and erythematous spots appearing on all parts of the body. 5. There was some fever, general malaise, nausea, and restlessness. *Homœopathic World*, March, 1892.

TYPHOID FEVER.

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(Read before the Germantown Medical Club, Philadelphia.)

TYPHOID FEVER (*enteric fever, abdominal typhus, ilio-typhus*).—A general, infectious disease, attended by a continued fever of gradual, progressive ascent, and stationary and descending fluctuations; by a rash of rose-colored spots; by a state of mental dulness and stupor; and by marked prostration. Characterized anatomically by infiltration, ulceration, and cicatrization of the solitary and agminated glands (Peyer's patches) of the intestines, tumefaction of the mesenteric glands, and splenic enlargement.

A. Etiology.—Endemic in large cities; epidemic; contagiousness doubted; never transmitted from person to person (Liebermeister); prevailing opinion that it is not generated by mere decomposition of animal excreta, but due to a specific germ (*bacillus of Eberth*) which is swallowed, passes through the stomach, and locates in the bowels, where it leads to the formation of the typhoid ulcer. Whether the *bacillus typhosus* is the real cause of typhoid fever is still doubted by some writers (Griffiths). According to Murchison, from decomposing sewage matter of any kind; conveyed by drinking-water polluted by human waste containing the germ (Prudden); by ice used in preserving food and for drinking purposes (Prudden, Dornil); by impure milk, rarely by the air, linen, or bedding (Lefort). According to Pettenhofer, four conditions are necessary for the production of this disease: (a) Unusual height of ground water, followed by rapid sinking. (b) Impurity of the soil from animal impregnation. (c) Heat of the soil. (d) Presence of a specific germ. Liability to disease markedly influenced by age (most common from fifteen to twenty-five years) and season (autumn), terror of contagion, errors of diet, defective sanitary arrangements, overwork and worry, either by favoring the putrefaction of the intestinal contents (*ptomaines*), or by placing the individual in a state of receptivity (Jaccoud, Dieulafoy).

B. Symptoms and Course.—Three periods: *ascent, climax, and decline*, coinciding with the *ascending, stationary, and descending thermometrical fluctuations*, and corresponding to the infiltration, ulceration, and reparation of the intestinal patches (Jaccoud).

1. *Outset.*—Sometimes *prodromes*, general *malaise, apathy, cephal-*

algia, pain in the limbs, lassitude, insomnia, restlessness, epistaxis; or a gastric catarrh, febrile or apyretic, temporarily relieved by vomiting; more rarely, *intermittent paroxysms* for three or five days, with continued *dejection* at the intervals, especially in ague-prevailing districts (Jaccoud); or *lobar pneumonia* (Potain); or *catarrhal sore-throat* (Dieulafoy); sometimes *no prodromes*; onset abrupt, with repeated chills for one or two days and fever.

2. *Ascent*.—Appearance or exaggeration of *prostration*, *headache*, *giddiness* and *tinnitus*, *photophobia*, *insomnia*, *dreams*, *epistaxis*, *anorexia*, *thirst*, *saburral coating down the centre of the tongue*, with red borders and red triangular tip, *diarrhœa* (not always present at this stage), *bronchitis*, *subcontinued fever*, with morning remissions, reaching its maximum (104°) by *ascending oscillations* in four or five days, rising every day, from morning to evening, 1° to $1\frac{1}{2}^{\circ}$, and falling, from evening to morning, $\frac{1}{2}^{\circ}$ to $\frac{3}{4}^{\circ}$ (Wunderlich).

3. *Climax*.—*Continued fever*, with very slight morning remissions (*stationary oscillations*), absent in severe cases; *pulse* accelerated, dicrotic, often soft and irregular (cardiac paresis). About the seventh day, *lenticular rose-colored spots* make their appearance, slightly elevated, disappearing under pressure, scanty and limited to the abdomen, or upon the chest and back, seldom in the limbs; in variable number they come out in successive crops, each spot lasting three or four days; average duration of the rash, as a whole, about fourteen days; occasionally *blue* or *brownish spots* (*taches bleues* or *ombrées*); at the end of this period *sudamina*. *Nervous symptoms*: *diminution of headache*, but *increase of tinnitus*, *giddiness*, *dreams*, and *prostration* (*dorsal decubitus*); temporary *deafness*, fatiguing *insomnia*, intellectual *torpor*, *somnolence*; *delirium calm*, with incoherent talk (*F. nervosa stupida* of the ancients), or *boisterous*, with much tossing about in bed (*F. nervosa versatilis*); *hallucinations*; *subsultus tendinum*; the noisy *delirium* is soon replaced by increasing *stupor*; the patient no longer recognizes those about him, but mutters incoherently, or picks vacantly at the bed-clothes, or lies motionless, with eyelids closed, yet can be roused for a moment and replies to questions, but in an inarticulate and unintelligible way. At this time the *tongue* trembles, or oscillates when protruded, or catches behind the teeth; the *lips* also tremble, the *nares* are pulverulent, the *alæ nasi* in active motion; finally he *slides down to the foot of the bed*, bathed or not in a *copious cold perspiration*, and the *impulse of the heart* is hardly heard or felt (degeneration of myocardium). *Gastro-abdominal symptoms*: *tongue* dry, brown, parched, cracked, stiff, parrot-like, or like a piece

of leather; *teeth* and *gums* covered with sordes; rarely vomiting; *pain* and *tenderness* on pressure, especially over *right iliac fossa*, where a marked *gurgling* under the hand usually exists; *tympanitis*, due to intestinal paresis and to accumulation of gases, and sometimes producing dyspnoea from compression of the diaphragm; *diarrhoea* (five to fifteen or more stools every day), typical, thin, pale-yellow, pulsaticeous, resembling pea-soup, very offensive, often involuntary, sometimes containing blood or bile; occasionally replaced by *constipation*, especially in children; *splenic enlargement*. *Respiratory symptoms*: *cough* slight; *mucous* and *sonorous râles* on auscultation; sometimes *broncho-pulmonary congestion*, with marked *dyspnoea*; *urine* scanty, high-colored, like brown beer, loaded with extractive principles, occasionally retained (*vesical paresis*); containing urea in small quantities, with pronounced typhoid symptoms, increased when the course of the fever is decidedly inflammatory (Robin); also albumin, retractile in test-tube with nephritis, non-retractile without it; dyscrasic (Bouchard).

4. *Decline*.—*Defervescence* by *lysis*, rarely by *crisis* (Jaccoud), commencing from the fifteenth to the thirtieth day; *temperature* remains higher in the evening, but less pronounced; morning remissions more marked every day (*descending oscillations*), the time taken to reach the normal is variable; *gradual diminution* of restlessness, delirium, insomnia, diarrhoea, tympanitis; the *urine* is more abundant, lighter in color, and of lower specific gravity; the *tongue* becomes moist at the tip and edges; the *pulse* less frequent, and tends to regain its normal characters. After six or seven days, *convalescence*, always protracted, sometimes interrupted by a *fever*, which appears without appreciable cause, lasts two or three days (Bernheim), has nothing in common with the febrile movement which occasionally follows the first attempts at alimentation, and is not the indication of a relapse (Dieulafoy); weakness and emaciation persistent; sometimes vomiting on first taking solid food; appetite returns in a voracious manner; *recovery* retarded by relapse, complications, or sequelæ.

5. *Complications, Sequelæ*.—1. *Digestive tract*: *intestinal hæmorrhages* (6 per cent.) usually from the fourteenth to the twentieth day (ulceration), sometimes from the eighth to the fifteenth (intense congestion or dyscrasic state of the blood); *peritonitis by propagation*, oftener *by perforation* (5 per cent., Griesinger), very rare in children (1 per cent., Rillet and Barthez), occurring principally on the third week, sometimes at the outset of convalescence with an insidious rather than abrupt invasion; occasionally *repeated vomiting*,

on the second or third week (Chauffard), with pain in the stomach and elevation of the epigastric temperature (Peter); simple, pultaceous sore throat, rarely diphtheritic; ulcerations on the pillars of the soft palate, tonsils and superior wall of the pharynx (Dieulafoy). 2. *Air-passages*: epistaxis very profuse; ulceration of the larynx (*laryngo typhus*), on the second or third week, rarely invading the vocal cords, producing occasionally necrosis of the cartilages and œdema of the glottis (Coyne); bronchitis, lobar and lobular pneumonia, sometimes tubercular during convalescence; gangrene of the lung (observed by Griesinger seven times in one hundred and eighteen autopsies). 3. *Circulatory apparatus*: endocarditis rare, but myocarditis common, cardiac paresis, phlebitis, endarteritis, dry gangrene. (The cardiac alteration explains in part the softness and irregularity of the pulse, the congestion of the lungs, the coldness of the extremities and the state of collapse). 4. *Nervous system*: paralysis of motion (hemiplegia, paraplegia), of sensibility general and sensorial, especially during convalescence (Landourzy), probably from peripheral neuritis (Pitres); symptoms of spinal meningitis or of myelitis (Raymond); intellectual troubles simulating mania, polymania, delirium of persecution, lasting a few days or weeks (Dieulafoy); complete but transitory aphasia, especially in children (Murchison). 5. *Albuminuria, nephritis; dropsies*, of mechanical origin (phlegmasia alba dolens) or dyscrasic, extended œdemas; myositis; parotiditis; bed-sores. 6. *Sequelæ*: paralysis, motor, sensory, or of special senses; tetany (Tocito); intellectual troubles, loss of memory, hebetude, idiocy, dementia, temporary or permanent (Behier); dropsy, œdema; orchitis (Dieulafoy); furuncles; abscesses, subcutaneous and muscular; purulent effusions in the joints or serous cavities (Dieulafoy); suppuration of gall-bladder (Lendet, Bernheim), of thyroid gland and parotid; acute periostitis, often suppurative, with or without necrosis of bone (Bourgeois); insomnia, extreme emaciation, prolonged debility, night-sweats, phthisis, anæmia; occasionally livid stripes on the skin of thighs and abdomen (Bouchard), temporary falling of the hair, especially in women; in young subjects growth is accelerated.

6. *Varieties*.—1. *Mild form (mucous fever)*: usually benign, attenuation of ordinary symptoms, rarely complications. 2. *Abortive form*: some febrile, gastric, general symptoms as in the mild variety, but ceasing from the seventh to the fourteenth day, with regular critical sweats (Jaccoud). 3. *Ambulatory form (walking typhoid)*: the symptoms are so few and mild that patients continue to walk and

eat as usual, thus being exposed to fatal peritonitis and perforation of the bowel. 4. *Adynamic form*: extreme dejection and prostration, profound stupor, deafness, calm delirium. 5. *Ataxic form*: restlessness, early and noisy delirium, hallucinations, strabismus, subsultus tendinum, convulsions. 6. *Ataxo-dynamic form*: alternation of the two preceding groups. 7. *Hæmorrhagic, thoracic, abdominal, bilious forms*; etc.: predominance of corresponding symptoms. 8. *Sudoral form*: nervous, abdominal and thoracic symptoms slight; continued fever, but attended with marked paroxysms and followed by copious sweats (Jaccoud). 9. *Infantile typhoid*: differs from that of the adult both anatomically and clinically; infiltration of Peyer's patches almost always under the form of *plaques molles*, which seldom ulcerate; the enlargement of the spleen and lymphatic glands very marked; perforations, peritonitis and hæmorrhages very rare; the thermic ascending oscillations usually absent, the fever acquiring rapidly a great intensity (Kunze) and remaining stationary, without marked remissions, for ten or fifteen days (D'Espine and Picot); the tongue remains moist, vomiting frequent, diarrhœa uncommon, tympanitis unusual, occasionally convulsive phenomena, little delirium, the rose-colored eruption discrete, the emaciation rapid, and disease terminates often with critical sweats; the neuropathic troubles, the ataxo-dynamic symptoms observed in children near puberty, are extremely rare in infants; pulmonary manifestations, especially lobular pneumonia are redoubtable in childhood and the relapses more common than in adult age, but the prognosis is less serious; frequent complications are diphtheria, eruptive fevers, whooping-cough (Dieulafoy), broncho-pneumonia and cerebral lesions more frequent than in the adult (D'Espine and Picot).

7. *Relapses, Second Attacks, Duration, Termination*.—*Relapse*, occasionally during convalescence abrupt return of the fever, with red-colored spots, abdominal, nervous and thoracic symptoms, but very slight, ending in recovery in from eight to twelve days; second or more relapses are very rare; less fatal than first attack. *Second attacks* are not relapses; they are rare and occur only several months or years after first invasion, probably due to a new infection, or to retention in the system of a certain quantity of morbid poison, which after a period of latency becomes active under the influence of pernicious causes. *Duration* total, eight to ten days (*abortive form*), twenty-one days (*common form*) and above (*severe form*). *Termination*: by recovery after protracted convalescence, interrupted by com-

plications; by *death*, from hyperpyrexia or complications; by *sudden death* from syncope, most frequent in ordinary cases at the approach of convalescence; due to a reflex action of intestinal origin (Dieulafoy), to degeneration of the muscular fibres of the heart (Hayem), to cerebral and bulbar anæmia (Laveran and Teissier), to heart-clot in individuals with thoracic complications (Marvand).

C. *Diagnosis*.—*Difficult* as a rule, *easier* at the period of acme; elements of decision: the *typical diarrhœa*, the *ilio-cæcal tenderness*, the *lenticular rosy rash*, the *splenic enlargement*, the *staircase-like range of temperature* (ascending, stationary, and descending oscillations), and the *enervation*; the best criterion in a doubtful case, the *pea-soup stools* which are alkaline and contain triple phosphates (Money); the presence of *Eberth's bacillus* in the stools is considered conclusive by some; *typhoid* is excluded if the temperature on the evening of the fourth day does not reach 104° F., or if the temperature on the first two days rises to 104° or more (Wunderlich), except in *infantile typhoid* where it may attain a high elevation from the outset (Kunze).

Differential: in *febricula* the ascent is abrupt, temperature on the first day rises as high as 104°, defervescence by crisis and follows close the ascension; in *typhus* the onset is sudden, the course shorter, the rash purpuric and continues going on to ecchymosis and hence resisting to pressure, the bowels constipated, and the brain bears the brunt of the disease; in *enteritis* the bowels alone are implicated, with frequent, watery, offensive, lenteric stools; cutting and gripping pains, tormina, no prodromes; in *peritonitis* the pain and tenderness severe, increased on the slightest pressure, associated with vomiting, distention and constipation, tendency to collapse, no preceding illness; in *meningitis* the premonitory symptoms are well defined and essentially nervous; development sudden, course rapid, with piercing headache, causing cries or shrieks, rolling of the head, inequality of pupils (Kunze), strabismus, retraction of abdomen, nausea, cerebral vomiting, constipation, convulsions, cutaneous hyperæsthesia, and extreme intolerance to light and sound; no rash, diarrhœa or splenic enlargement; *appendicitis*, *pyæmia*, *ulcerative endocarditis*, and *trichinosis* have been sometimes confounded with *typhoid fever* (see these affections); diseases which offer the greatest difficulty in diagnosis are: *acute miliary tuberculosis*, *tubercular ulceration of the intestines*, and *acute tubercular peritonitis*; "the first difficulty may be overcome by remembering that enteric fever rarely affects tubercular or phthisical people, and that tubercular ulceration of the intestine is nearly always associated with tubercle in the lung,

and that given a patient with phthisis and appearances like enteric fever, the probability is that the cause of the enteric symptoms is tubercular ulceration." (Collie).

D. *Prognosis*.—*Favorable*, without complication, and with moderate rises of temperature (102° to 103°), other things being equal. *Unfavorable*, with complications, or with protracted high temperature and profound stupor; protracted high temperature after the end of the second week, without marked morning remissions; steadily progressive frequency of the pulse, with notable dirotism, and failure of first sound of the heart are *unfavorable signs*; presence of well-marked morning remissions about the tenth or twelfth day, with decreasing evening rises, moist skin and tongue, disappearance of the stupor and a calm sleep, *announce the approach of recovery* (Kunze); *more favorable* in winter than in summer, and in children than in adults; perforation is *very rarely recovered from*; hæmorrhages are *not so mortal*; relapses are *less fatal* than first attacks; *death* usually at the end of third week, but may occur early from hæmorrhage, or during convalescence from perforation, leading to peritonitis. This is to be feared when, after an attempt at recovery, the patient still suffers from irritable bowels, with occasional hæmorrhage, the tongue remaining preternaturally red at tip and edges, and the pulse frequent (Husband). When perforation takes place, the abdomen suddenly swells and becomes excessively tender, the patient generally dying in three or four days.

E. *Pathological Anatomy*.—*Seat of essential lesions*, *Peyer's patches and solitary glands*, more marked in the groups near the *ilio-cæcal valve*. *Process* comprises three successive stages: *infiltration, ulceration, cicatrization*.

1. *Infiltration*.—Towards the fifth day the solitary glands are raised, conical, hard; the Peyer's patches present distinct projections above the level of the mucous membrane, their number varying from two or three to thirty or fifty, resisting when the alteration is intense (*plaques dures*), yielding in a contrary case (*plaques molles*). These sectional projections exhibit a whitish, soft tissue, exuding a small quantity of liquid (*medullary infiltration*). Both solitary and agminated glands are infiltrated with lymph-cells, some of which are increased in size, globular, polygonal, containing granular protoplasm, and having one or various nuclei (*cellules typhiques*). At the level of the projections, the *villi* are enlarged and infiltrated with the same class of cells; the crypts of Lieberkühn are increased in length and width, and the connective tissue which separates them, and is situated underneath, is also filled with these corpuscles (Cornil).

2. *Ulceration*.—Some infiltrated follicles and patches may undergo retrogressive changes, disappearing by simple atrophy and reabsorption (Bard), but the greater part break down by molecular necrosis, and after the necrosed parts are thrown off, *ulcers* are formed (Kunze). The *ulceration* extends almost always in a direction parallel to the long axis of the intestine, and never leads to stricture, thus differing from the *tubercular ulcer*, which has its long axis transverse to the intestine, is usually circular (Kunze), and often followed by stricture. On the *soft patches* the ulcerative process is slow and may remain superficial, but more frequently it is deep and extended. It commences in the centre of the patch, which, from gray and transparent, becomes yellowish and opaque. Then a small slough is formed in the most prominent point, and its elimination leaves a longitudinal ulcer located on the free border of the mucous membrane, where it extends progressively. The mucous membrane, the submucous tissue, and the muscular coat are successively destroyed. The peritoneum exhibits, then, whitish, opaque patches, differing from *tubercular infiltration* by the absence of granulations and caseous degeneration (Cornil). The *typhoid ulcer* has a thin, smooth base, formed by one or more of the coats of the intestine, according to its depth, and undermined, overhanging, thin edges, formed by the inflamed mucous membrane. When the process is active, *perforation* may result, either by extension, sloughing, or laceration (Carter). Usually the ulceration brings about the obliteration of the neighboring vessels by thrombosis and endarteritis; but when the process is rapid it may reach the vessels and produce hæmorrhage. Occasionally, some of the follicles of a patch remain intact, in which case the part is studded with projections, and has a honey-comb appearance.

3. *Cicatrization*.—Occurs usually during the fourth week, and is brought about by the development of fleshy buds on the surface of the ulcer, and by the union of the edges. The ulcer heals from its circumference, with no tendency to puckering or constriction. The cicatrice is distinguished by its black or slate color, by the thinning of the intestinal walls at its level, and by the smooth appearance of its surface. As a rule, the cicatrices left after healing, eventually disappearing.

Concomitant Lesions.—The *mesenteric glands* become congested, enlarged, and infiltrated with the typical lymph-cells; sometimes they contain pus, or, finally, atrophy. The *spleen* is hypertrophied and infiltrated also with lymph-corpuscles. The *muscles* often undergo a waxy or lardaceous degeneration, most common in the

adductors of the thighs and in the recti abdominis. The *myocardium*, as well as the *liver* and *kidneys*, are in a state of parenchymatous inflammation. The *lungs* are either œdematous or congested, or, in occasional cases, actual pneumonia is present (Taylor). The *larynx* is the site of erosions and ulcerations, lesions easily understood if we remember that the mucous membrane of the larynx is composed of a lymphoid reticular tissue and of adenoid follicles, a structure comparable to that of the intestinal mucosa. The pharynx presents also special lesions similar to the above.

F. *Treatment*.—*Bryonia* is indicated in the early stage of the disease, before the senses are perverted, principally with gastric catarrh, without diarrhœa. The patient complains of epigastric tenderness, a peculiar lassitude and heaviness of limbs, general soreness and splitting headache. He vomits food and bile, the tongue is white and dry, the appetite is lost and the sleep is restless. Additional indications are: vertigo and nausea when sitting up in bed, constipation, empty eructations, nose-bleeding; a nightly, calm delirium about the business of the day, a desire to go home if travelling, and the aggravation from motion. *Baptisia* takes the place of *bryonia* when there is a predominance of nervous phenomena, and an early, yellowish, papescent diarrhœa, with abdominal tenderness and gurgling is present; but it is also indicated later, if the discharges are dark and offensive, the mouth is very dry, the tongue is covered with a yellowish-brown fur down the centre, the taste is flat or bitter, the face flushed, the eyes injected; the patient presenting a besotted expression, being very weak and drowsy, and complaining of much muscular soreness, always finding the bed too hard. Offensiveness of the discharges, putridity of the exhalations, excessive prostration, and that peculiar perversion of the mind in which the patient imagines that his body is scattered and tosses about to get the pieces together, are characteristics of this drug. *Rhus tox.* usually follows the preceding remedies. It seems to come into play when the temperature has reached its maximum, and the increasing prostration and typical diarrhœa indicate the establishment of infiltration. It is particularly indicated when the yeast-like or pea-soup stools continue in the increase; the tongue presents a red triangular tip, with the apex posteriorly, or is covered with brown mucus; the nose bleeds with relief of condition, and a dry cough annoys the patient, who at the same time is compelled to a constant change of position to find relief from rheumatoid pains of the extremities. Additional indications, in a more advanced condition, are: increased

prostration, stupor or heavy sleep, difficult ratiocination, the speech which was first coherent and intelligible, dwindles away into an inarticulate murmur, indicating that the mind is so depressed that it is not capable of continuous thought; there is a calm delirium with great deal of self-talk; the abdomen is tender and tympanitic; the tongue then is dry, rough, cracked, brown, woody; the teeth and lips are covered with sordes; the stools become thinner, more copious and offensive, even bloody, or involuntary, especially at night; and the urine is dark and muddy, sometimes involuntary and may contain albumin. This concurrence of erethism and depression makes this remedy eminently suitable to the ataxo-adyynamic form of the disease. But when the typhoid state has reached its climax, ulceration has commenced to do its deadly work and rhus tox. has not been able to modify the advancing toxæmia and destruction of tissue, we must then direct ourselves to deeper acting remedies. Among them we should first consider *Arsenicum*, which like rhus tox. combines erethism with depression, but in a higher degree, and hence is also suitable to the ataxo-adyynamic form. It is indicated when the general condition assumes a graver erethistic form, more malignant, the vital functions are more thoroughly perverted and more profoundly excited, and the blood and organic substance more extensively altered, especially when an extreme prostration marks the approach of dissolution. At this stage it shares honors with carb. veg., but in *Arsenic* no matter how intense the prostration the patient still remains irritable and anxious, even to the last hours of life, whereas in *Carbo veg.*, the torpor is complete and collapse is imminent or present, without the least sign of erethism. The gastric and abdominal symptoms of arsenic are also very important. The thirst is intense, with tendency to drink little and often, the gums and teeth are covered with sordes, the tongue presents a dark brownish coat, the mouth is full of blisters and aphthous ulcers, which bleed easily; dysphagia may be present (œsophagal paresis), the bowels keep on ejecting the products of decomposition in the shape of bloody, or brown putrid fæces, and they are more active at night; the tympanitis is not marked (intestinal paresis); hæmorrhage from the bowels, if present, consists of dark, watery blood; there is pain on pressure on the ileo-cæcal region, and the spleen is enlarged and sensitive. The nose-bleed, melæna, ecchymoses, and petechia, all indicative of this drug, are symptoms of blood decomposition. Moreover arsenic is a drug which exerts an intensely paralyzing effect upon the muscular tissue of the heart. It is indicated when a soft weak, irregular pulse with

tumultuous action of the heart and absence of the second sound, reveals the impairment of the myocardium ; and finally the hyperthermia ; the striking and typical remission of the fever, having the appearance of an actual intermission ; the scanty and retained urine, and the paroxysms of sudden collapse towards midnight, point prominently to this drug. *Muriatic acid* is also an erethistic remedy, but its erethism, like that of phosphorus, is transient, for its early excitability is followed soon by depression. It bears some points of resemblance with arsenicum and both when indicated seem to have the power to subdue the intestinal hyperæmia and consequent diarrhœa. According to Trinks, it is rather applicable to erethistic conditions too severe for bryonia, too sthenic for rhus, and not cerebral enough for belladonna. It does not only modify the evacuations quantitatively but qualitatively. It corrects putridity, a change which carries with it other phenomena, producing a general improvement. Hence it is the remedy when the putrid decomposition of the fluids has reached the highest degree of intensity, and there is a general state of paresis ; the strength is all gone, the muscles refuse to do their work ; the patient slides down in bed, groans and moans, or is entirely unconscious, with muttering delirium ; the tongue from dry and shrunken, may become parrot-like and so heavy that the patient is unable to move it, or protrude at will ; the gums and teeth are covered with sordes. At this stage the pulse intermits every third beat ; the heart though quick and irritable, lacks energy and force, showing the condition of its wall ; the diarrhœa is watery, offensive, greenish or bloody ; the urine as well as the stools escapes involuntarily, the former may be scanty or turbid, like the dregs of a cider-barrel, the latter passed unnoticed while urinating, and finally the vacant, staring eyes, the dropping of the lower jaw, and the coldness of the extremities indicate threatening paralysis of the brain. Putrid, ulcerated sore-throat as a complication, also points to this remedy. *Phosphoric acid* is a drug suitable to the adynamic form of the disease with its extreme debility and prostration, profound stupor, deafness and calm delirium. No remedy can take its place from the moment we notice that the patient has become indifferent and unwilling to speak, especially if his face is pale, the stools yellow, watery with meal-like sediment ; there is general tympanitis with rumbling and gurgling, and he complains of a stupefying frontal headache. It often follows rhus after the restlessness has ceased and the patient falls into a state of stupid apathy or unconcern, and insensible to every external impression. A characteristic of this drug

is, that notwithstanding the marked sensorial depression, the patient is easily aroused and is then fully conscious, but soon sinks back again into his former stupor, differing in this respect from *helleborus*, whose patient cannot be aroused to full consciousness. Another adynamic remedy of great value is *helleborus*. It is indicated when the disease makes a deeper inroad in the brain, the senses are thoroughly perverted, the muscles do not respond to stimulus and we are unable to rouse the patient to full consciousness. There lies the *helleborus* patient a perfect picture of idiocy and thorough unconsciousness, overwhelmed by utter prostration, sinking to the foot of the bed, in a helpless condition, making no effort to change or preserve his position. He has a vacant look, stupid expression, wide open eyes, dilated pupils, and pulverent nostrils; his muscles twitch convulsively and he picks meaninglessly at the lips or clothing. The urine may be scanty, retained, or albuminous; the feces escape involuntarily, the tongue is yellow and dry, with red borders, or slightly protruded and oscillating, the breath very offensive; drinks roll audibly into the stomach; the body is bathed in a cold clammy sweat, the pulse is faint, weak, almost imperceptible; the heart-beat weak and slow, and the delirium is quiet, with unintelligible muttering. The erethism of *phosphorus* is so transient, that I think it is hardly indicated in the early stage of the disease. Its profound and disintegrating action upon the blood-life makes it essentially a late remedy. Its prostration is nearly akin to that of muriatic acid, and you may find its patient sunk in stupor at the verge of a condition calling for *carbo veg.*, with a small, filiform pulse, hippocratic face, contracted pupils, dry, flapping nose, blue lips and open mouth, exhibiting a black, dry, cracked, immovable tongue. Other symptoms indicative of this remedy are, vomiting of bilious, slimy masses; meteorism with loud rumbling; bloody stools, looking like flesh-water; black, like coffee-grounds; involuntary, out of a wide-open, paralyzed anus, followed by great weakness; scanty, albuminous urine; cold, dry skin; profuse sweat, without relief; great heat of trunk with cold perspiration on hands and limbs; roseola spots, miliary eruption, ecchymoses, and enlarged liver and spleen. Its place in the adynamic form, when there is impending paralysis of the lungs, is prominent. The patient lies in a comatose condition, with hot breath and rattling breathing (from accumulation of phlegm), the limbs are cold and covered with a cold sweat, and the pulse is scarcely perceptible. It is a valuable agent in pulmonary and cardiac complications. According to Jahr it has the power

to arrest the pulmonary difficulties of the inflammatory period and the dangerous progression to the severer stages, especially when rhus tox. has failed to do its work. In the hæmorrhagic and sudoral forms it should also be studied. If, notwithstanding the proper administration of the above remedies, the disease should go on in its onward course to destruction, and we find the patient in a state of algid collapse, without the least sign of reaction, we must then turn to *carbo veg.* as a last resort. This drug has often brought about the most marvellous change for the best. Under its administration I have seen the cold, inanimate, pulseless patient recover the vital warmth, the pulse gain in volume, and the heart enter into proper rhythmical action. Among its leading indications we find a death-like asthenia; dull, lustreless eyes, immovable pupils; hippocratic face, extinct voice; cold surfaces, cold sweat, cold breath, cold nose, blue lips; dry, black tongue; small, filiform, nearly imperceptible pulse; cardiac failure; tympanitic distension of the abdomen; dark-brown, horribly foul, involuntary stools; offensive odor of the body; suppressed urine; impending paralysis of the lungs; extensive pulmonary hypostasis; hemorrhages, and abundant petechiæ.

Other remedies not so prominently indicated, but which nevertheless may sometimes be indispensable, are the following: *Gelsemium* is an early remedy, which may precede baptisia before the senses are markedly perverted, if there is malaise, muscular soreness, headache, tinnitus, giddiness, or a sense of expansion in the head, and these symptoms are accompanied by chills or creeps down the back, severe pain in the back and limbs, lassitude, loss of muscular power, suffused red face and drowsiness. Afternoon increase of fever with marked morning remissions, is an additional indication. *Hyoscyamus* and *belladonna* may be required if the delirium is violent; stupefaction, unconsciousness, or lascivious mania, point to the former. Cerebral congestion with red face, dilated pupils; photophobia, hot, pungent skin, and embarrassed speech point to the latter. *Stramonium* has a more furious delirium, with all sorts of hallucinations, and desire to escape out of bed, but loquacity and a mania for light and company, are its characteristics. *Opium*, besides being one of the best remedies we have for retention of urine, is prominently indicated when the coma is profound, or the sopor threatens to terminate in paralysis of the brain. Stertorous breathing, with open mouth and depressed lower jaw, would announce this fatal end. *Lachesis* is indicated when loquacity precedes the symptoms of depression. Its delirium is of a low muttering type, and its trembling tongue, catch-

ing in the teeth when asked to protrude it, clearly shows the effect of the typhoid poison on the brain. In impending paralysis of the brain it shares honors with opium. Hyperæsthesia, fainting, trembling and foul discharges are additional indications. *Arnica* is the remedy when the fever sets in with complete stupefaction and involuntary defecation and micturition. If conscious, the patient complains that the bed is too hard, and that he is sore and bruised all over, etc. *Mercurius*: I do not see how a remedy so rich in gastric, hepatic and intestinal symptoms can be discarded in typhoid. The prodromic stage is sometimes initiated by a gastro-enteric catarrh, and in such cases if, instead of constipation, we find green, bilious, mucous stools, with frequent urging and tenesmus, and a jaundice-like color of the face, we must give this remedy a preference over bryonia, especially if there is a tendency to perspire without relief, and the stools are preceded by chilliness. The consideration of this drug becomes still more imperative when peritonitis complicates the case and suppuration has commenced. *Veratrum alb.*, if the vital powers suddenly sink to the lowest degree, with cold sweats, thready pulse, and paroxysms of syncope. *Cocculus*, if the least exertion brings on prostration, with an invincible disposition to sleep, falling soon into apathy, and ending finally in coma. Vertigo, nausea, inclination to vomit, and even fainting, are among its symptoms; but confusion of mind, with embarrassed speech, is one of its leading indications. *Acidum nitricum* is sometimes indicated in the advanced stages, when there is marked sensibility of the abdomen, ilio-cæcal pain, gurgling and soreness of the bowels, and especially if a persistent bloody diarrhœa announces the establishment of ulceration. In laryngeal complications it forms a useful group with *mercurius*, *kali jod.*, *iodum*, etc. *Digitalis* may be needed if there is impaired cardiac action, with a feeble, intermittent pulse, etc. *Apis*, *cole. carb.*, *castoreum*, *cinchona*, *colchicum*, *lycopodium*, *nux vom.*, *petroleum*, *sulphur*, *sweet spirits of nitre*, *taraxacum* and *terebinthina* may be required occasionally, and in Dr. Farrington's *Clinical Materia Medica* we can find their indications.

The diet, nursing, ventilation, disinfection and speedy removal of excretions and soiled linen, imperatively demand our most solicitous attention, and no less can be said of convalescence.

Myrtus communis has pains in the upper left chest, through to shoulder blade, a symptom it often relieves even in consumption.

URETHRAL MEDICATION IN THE MALE.

BY C. A. PAULY, M.D., CINCINNATI, O.

(Read before the Homœopathic Medical Society of the State of Ohio.)

THE anatomist divides the male urethra into the pendulous, bulbous, membranous and prostatic portions. For practical reasons it has been found most convenient to divide the urethra into two parts by the cut-off or compressor urethra muscle, which is located in the membranous portion. The anterior urethra extends from the meatus to the "cut-off" muscle. The posterior or deep urethra includes the remainder of the canal, extending from the compressor muscle to the neck of the bladder, and consists of a part of the membranous and all of the prostatic portion. The posterior portion is really the neck of the bladder, as it forms one cavity with the bladder whenever the latter becomes distended. The internal sphincter, unable to resist longer, readily yields to the pressure of the urine, while the involuntary contraction of the compressor prevents the escape of water; by its relaxation, which soon follows, the urine is easily voided. The cut-off or compressor muscle controls the function of the bladder, and not the sphincter, which is located within the prostate. The most frequent and the most violent disease to which the urethra is subjected is gonorrhœal urethritis. The anterior portion is the first to be infected, and the seat of greatest inflammation is in the fossa navicularis and the sinus bulbi. These cavities are the most common locations for stricture. The inflammation very seldom extends beyond the cut-off muscle, unless induced by forcible injections of large quantities of fluid or the premature introduction of sounds. So long as there is a thick, creamy discharge from the anterior urethra, and the meatus is swollen and œdematous, sounds should not be used. When acute gonorrhœa has been mismanaged it is liable to pass into a chronic state, or what is better known as gleet. Gleet is not a disease; it is a symptom of some morbid condition. There are structural changes in the mucous lining of the urethra which cause and perpetuate gleet. There may be present spots of congestion or chronic inflammation, patches of granulations, inflammatory thickening or stricture and chronic folliculitis. These different pathological conditions give forth a scanty and sometimes a thick discharge, which appears at the meatus urinarius in the form of glairy mucus, or as drops of yellow pus.

Discharges secreted in the post-urethra do not show at the meatus, but simply collect at the neck of the bladder and are washed out by the urine. Burning in the anus, pain in the region of the perinæum and frequent micturition are some of the marked symptoms of post-urethral catarrh. A practical test for determining the seat of urethral inflammation is given by Ultzmann: "The patient is made to pass his water consecutively into two tumblers, so that the amount voided should be about evenly distributed in the two vessels. Whenever the anterior urethra alone is the seat of inflammation, only the first half of the urine will be turbid, or at least will be found containing flakes and threads; the second portion will appear perfectly clear. In cases of deep-seated urethritis, the first tumbler will receive flaky and turbid urine, and the water held by the second glass will appear also turbid, but less so than the first portion." Inflammation, acute or chronic, specific or non-specific, involving the deep urethra, has a more severe effect on the general nervous system than diseases of the anterior urethra. In the deep urethra is found the centre of the reproductive system, which is closely related to the nervous system. Irritation and inflammation of the deep urethra is the cause of post-urethral catarrh and functional disorders of the reproductive organs, as seminal emissions, premature emissions and impotency. Strictures of larger calibre located in the deep urethra are the result of continued irritation and inflammation. They are one of the most common causes of chronic impotency. Chronic hyperæmia and hyperæsthesia of the prostatic portion excites the passions and leads to abuses and excesses, which are one of the causes of sexual neurasthenia. When any or all of these morbid conditions become more or less chronic, the nerve centres become impaired and the nervous system is depressed and weakened. These changes are made known by the following symptoms: Pain at the base of the brain (basilar neuralgia), sensitive spots along the spine, backache, tired, languid feeling on rising in the morning, easily fatigued, weak memory and disturbed digestion. Dr. Fothergill, in his writings, speaks of persistent dyspepsia associated with some morbid conditions of the reproductive organs in woman. He calls it "reflex indigestion." When the diseased ovary or womb has been restored the dyspepsia disappears. The term reflex indigestion will apply to the male as well as the female. The morbid influence of disease on the reproductive centre will be felt by any part or all of the nervous system.

In the treatment of diseases of the male urethra much can be

done by internal medication with homœopathic remedies. In the treatment of gonorrhœal urethritis we are unable sometimes to bring about a cure with internal medication alone; then again there are cases of specific urethritis that we do not see until they have become chronic, when there are secondary changes in the mucous and submucous tissues. In the latter stages of acute gonorrhœa much can be done towards perfecting a cure by urethral irrigation. Introduce one of Lindenschmitz's urethral irrigators as far as the cut-off muscle; to the end of the instrument attach the hose of a fountain syringe that has been filled with a warm solution of permanganate of potash, 1-2000. Two quarts of the fluid should be used at each sitting, and the number of sittings should be two each day.

If the posterior urethra and neck of the bladder have become infected, a solution of the same drug 1-5000 should be used. After the anterior urethra has been irrigated, the instrument is passed beyond the cut-off muscle to the neck of the bladder, the parts being thoroughly medicated. While the instrument is located behind the cut-off muscle the fluid enters the bladder. When the instrument has been withdrawn the injection fluid is passed off voluntarily by the patient.

A pint of the solution should be used at one sitting. For the treatment of patches of granulations, irritable follicles and incipient stricture in the anterior urethra very little benefit is derived from internal medication or from irrigation. The application of a 5 per cent. solution of nitrate of silver made through the endoscope will cause absorption and hasten the disappearance of these structural changes. Application of the "cool sound," to these inflamed surfaces proves beneficial on account of the dilatation produced by it and the sedative effect of the cold.

In the treatment of chronic catarrh of the deep urethra or neck of the bladder gradual dilatation with full-sized sounds is not satisfactory and may lead to epididymitis in some cases; some benefit may be obtained from irrigation of the parts with a solution of permanganate of potash. Nitrate of silver, however, is the most efficient remedy and will give excellent results if properly used. The milder solutions, one or two grains to the ounce of distilled water, should be applied with Keyes' deep urethral syringe twice a week. The strength of the solution can be increased, and the amount injected increased or lessened just as the case demands, great care being used not to cause too much irritation. The use of both the cool and

hot sounds play an important part in the treatment of post-urethral diseases. By their use inflammatory conditions are overcome. Prostatorrhœa which is due to chronic inflammation of the urethra is cured. Hyperæmia, hyperæsthesia and irritability of the muscular lining of the seminal vesicles and ejaculatory ducts are removed and sexual neurasthenia becomes a thing of the past.

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THE urgent request of editorial friends is my only apology for appearing in the rôle of an autobiographist.

If I have done anything, or had anything happen to me in the course of life, the record of which may be of use to others, I suppose modesty should not forbid my furnishing the brief sketch that is asked for.

I am a native of New York, not a bad state to be born in.

My father was a physician and, so also, two of my brothers. Half a century ago they turned from the old school to the new. I was kept at school continuously, with an interruption of only one year (while exercising as a pedagogue in Tennessee), till I graduated under the celebrated President Eliphalet Nott from Union College, Schenectady, New York, in 1849, at the age of twenty-two. My study of medicine was under the preceptorship of Dr. Gustavus Reichhelm (from the University of Halle, Prussia), at Pittsburgh, Pa., who had the honor of being the first to practice homœopathy west of the Allegheny mountains, beginning in 1837.

I attended lectures at the Geneva Medical College (old-school), and afterward at the Homœopathic Medical College of Pennsylvania (now the Hahnemann), at Philadelphia, graduating therefrom in 1851.

While in Philadelphia I enjoyed the friendship of Drs. Hering and Williamson, and especially of Dr. Neidhard, with whom I spent many hours of profitable conversation, and who, alone, of the old faculty is yet living, crowned with honors as with years.

Returning to Pittsburgh after graduation, I soon became a partner, and in 1853, the successor of Dr. Reichhelm.

The first of my writing on the merits of the new system of therapeutics was an essay, read before the senior class at Union College in 1848, and afterwards published in a Schenectady paper by Dr.

Swits. It was entitled "Generalization in Medicine," written to illustrate logical methods.

In 1849, while yet a student, I took a hand in the fight with Asiatic cholera at Pittsburgh, and also in the controversy that sprung up in the newspapers in regard to its treatment. I was so imbued with a high conception of the scientific character of a system of therapeutics based on a natural law, I was ready to contend with the biggest allopathic Goliath, however mighty he might be in wielding the lancet or the pen!

In April, 1855, I was invited to deliver one of the orations at the centennial celebration of Hahnemann's birthday in Philadelphia. I was pleased to meet there, as my fellow-orators, Dr. Joslin, the senior, and Dr. Bayard, of New York, both of them my fellow alumni from Union College. In the autumn of the same year, I was called to the chair of materia medica in my alma mater at Philadelphia. I took the chair with no little misgiving, in view of my youthfulness, and the importance of the teaching demanded. And my embarrassments were not lessened (I must now confess), upon subjecting the literature of my branch to a more urgent and critical examination. Some of the causes of my trouble I laid before the American Institute, in a paper I read at Chicago, in 1857.

In regard to the Institute I should mention, that I first saw it in session at New York, in 1848, when it was but four years old. There were present Drs. Jeans, Williamson, Kirby, Cator, McManus, Wells, Payne, Gregg, now gone to their rest, and Marcy, Paine, and a few others, yet lingering among us. I became its general secretary, at Buffalo, in 1855, and by notices in the journals and circulars, succeeded in greatly increasing the attendance, the following year, at the city of Washington. I moved to have the next meeting in Chicago, and after an hour's debate succeeded in my purpose. Drs. Williamson and Swazey feared that, to go so far west, where there were comparatively so few to attend, and they so scattered in the woods or over the prairies, the society would be inevitably ruined. But the Chicago meeting was large and lively.

I was elevated to the presidency, and Smith and Ludlam led the way in giving the Institute the first regular banquet, with toasts and the music of a brass band, known in its history.

In such a young, vigorous city, and with such an enterprising local committee, to say nothing of the young president, why shouldn't there have been something fresh and festive?

As to college work in Philadelphia, my growing business at Pitts-

burgh compelled me to resign it after two years. It was a trial to me to do so, because I was fond of teaching and of being among students, even though my branch was the least exact and most trying of all.

In 1863 impaired health obliged me to retire to my farm in Ohio. I turned my back upon a clientèle, in quality at least, second to that of no medical man in the city of Pittsburgh. Pomology interested and restored me to health.

Before passing I should say that, it has always been a pleasure to me to encourage well educated young men in the study of homœopathy; and that I now look back with some degree of pride to those who have been under my preceptorship, at one time or another. As fair specimens at old Pittsburgh, I may name Drs. David Cowley, J. C. Burgher, James A. Heron, J. S. Rankin, William R. Childs, William I. Church, and James H. McClelland, some of whom yet live and enjoy a national reputation.

In 1869 I was compelled to seek a home in a milder climate for the safety of my wife, and removed to Nashville, where I announced myself as a practitioner of the new-school. Homœopathy had just fairly begun its work in the south when the civil war came to place a bar in the way of its progress, and the in-coming of more practitioners; so I found myself almost a pioneer again, in an attractive field and among a most hospitable people. Business rolled upon my hands, till in a few years I was again broken in health.

In 1873 I was in a hard fight with the old enemy of 1849, Asiatic cholera. When the smoke cleared up and a count was had, homœopathy was found to have won another great victory. In my list of cases the loss had been less than 2 per centum.

In 1875 I was compelled to leave my work and go across the ocean. Travel and new scenes, with my old friend Dr. Rush, restored me to vigor after a few months in Europe.

The first World's Homœopathic Congress was opened in Philadelphia in 1876. In obedience to programme, I read a paper, intended to be a discussion of an essay by Dr. Hering, on "*Materia Medica as a Science.*"

The same year I was called again to a chair in my medical alma mater,—this time to the chair of "*Principles and Practice.*" I continued only the one year, being obliged, by my wife's inability to remain so far north in winter, to resign and remain in Tennessee.

In 1878 I was appointed and served on the "Yellow Fever Com-

mission," organized to inquire into the treatment as well as preventive measures resorted to during the great epidemic along the lower Mississippi and in my own State.

In 1881 I was again in England to attend the second World's Congress of Homœopathic Physicians. By appointment, I read a paper on "Drug Attenuation." I should mention that I was greatly pleased to meet and mingle with my English *confrères* at their elegant and hospitable homes, as well as at the Congress. The profession, especially in English-speaking countries, owes a large debt of gratitude to our writers in Great Britain. Dudgeon's *Lectures* and the writings of Drysdale, Black, and other learned and wise associates in the *British Journal*, at an early day, saved our cause from the destruction imminent by reason of transcendentalism (nihilism of dose), and the indiscriminate gathering and remorseless dismembering of all reported drug symptoms.

Soon after the adjournment of the Congress, in company with my friends, Dr. and Mrs. Talbot, of Boston, I travelled through Holland, North Germany, Denmark, and Sweden, and then, with a medical friend, across into Finland and Russia, and afterward through Norway and back to England.

Before passing, I should mention that in Amsterdam Dr. Talbot, another medical friend, and myself called upon Dr. Metzger, celebrated as having cured the Queen of Sweden and the Queen of Spain after the failure of the physicians in their respective countries. He received us cordially, and showed and explained to us his mode of treatment in two cases.

On inquiry, he stated that he depended little upon drugs; chiefly on massage and Ling movements, as called for by the pathology of each case, and a knowledge of vital mechanics. Patients were flocking to him from all parts of Europe.

In 1885 I crossed the ocean again, chiefly for the benefit of my third son, J. P., Jr., whom I took to Wiesbaden for the thermal and saline waters. The saddest experience of my life came the next year in his death, at the age of thirty years.

In my several trips abroad I visited some of the best hospitals to observe their outfit and modes of management. I must say many of our own hospitals suffer nothing in a comparison with them.

Recurring to the American Institute, I should say that I have done work on several of its bureaus, but chiefly on that of *materia medica* and pharmacy. I there brought forward criticisms upon the inexact and insufficient provings of drugs as commonly made, and

the consequent unreliable character of our pathogenesis, and recommended plans for improvement.

As chairman for two successive years, I had the whole bureau at work upon the objects and results of drug attenuation. For the London Congress of 1881, as already mentioned, I prepared a paper summarizing the results of our inquiries.

I hardly need say that I attended the great World's Congress at Atlantic City and took part in its proceedings. I delivered one of its special addresses, my subject being "Civil Government and the Healers of the Sick." It has been my privilege to attend all the largest gatherings of homœopathic physicians in the world, and I can truly say that none of them came up to that held last summer at Atlantic City.

I have written a great deal in my time on medicine, beginning, as I have mentioned, when I was an undergraduate at a literary college. The files of our leading journals and the *Transactions* of our national society, covering a period of more than forty years, show much of my work, as well as my views, on current medical topics. In conclusion of my outline narrative, submitted without embellishment, I must make mention of some of the leading thoughts and purposes that have generally led me on :

1. In the first place I deemed it important to bring to my professional studies a mind well trained and properly stored with classical and scientific information, to enable me to deal critically with the great problems of the healing art.

2. To me it seemed wise to avail myself of the best ways and means, the best helps devised, to prepare me for professional duties.

3. In practice I adopted, and have constantly adhered to, a plan for the recording of my cases, as more than thirty portly volumes of records on my shelves will testify.

4. In my writings I have seldom ventured to display cases and prescriptions for the very reason that prevented Hahnemann's doing so, namely, the faith one should have in the homœopathic law applied to a pure pathogenesis. A knowledge of drug effects in the healthy, and a faithful comparison of them with the symptoms of each case presented for treatment, has seemed to me of infinitely more importance in practice than a reliance upon the revelations of clinical experience, a source fruitful of all manner of empiricism and uncertainty.

My medical logic has had the law as one premise, a pure pathogenesis as the other, and a safe cure as the conclusion.

To me my clinical experience has by no means been useless, however. It has widened and also rendered more definite my views of disease on the one hand, while it has familiarized me, by many comparisons, with the characteristics of medicines on the other. It has made my work more expeditious and satisfactory—especially has it enabled me better to determine if a case calls for the homœopathic remedy, or rather, for some hygienic, mechanical or chemical, or simply palliative measure. It has surely helped me to judge between doses variously attenuated, and as to the proper frequency of repetition.

5. My writings have not abounded in observations intended, from my clinical experience to stamp the essential value upon drug symptoms, rating some as key-notes or characteristics; nor have I dared to gather symptoms from the sick room and publish them as positive drug-effects, worthy of a place in the *materia medica*.

In my judgment the characteristic and sure effects of various drugs must be distinguished from the personal or casual in the prover, in one safe way only—that of repeated and thorough trials upon the healthy.

6. As a busy practitioner, often physically weary and mentally worried, exposed to all manner of disturbing influences, I have never regarded myself or others similarly situated, as proper provers of drugs; and hence I have most strenuously advocated a college of drug provers, where students of medicine, male and female, under skilled supervision and with all needed means for observing and noting symptoms, may be gathered for a few months each year and employed in originating material for a *materia medica*.

It affords me great pleasure to find the profession, at last, moving in the desired direction, as shown at the last World's Homœopathic Congress.

7. I have always favored medical journalism. For years I took every homœopathic journal published in this country and in England; but the number has become so great I am obliged to select out those I consider the best.

8. I have been a "society man;" not in the common acceptance of that term, but as in favor of social medical organizations. In our early history it was plainly necessary for our practitioners to come together, not only for mutual improvement but, as well, for mutual encouragement and defense.

I am proud of the American Institute of Homœopathy; what it is and what it has done; and I hold that no physician in this country,

who professes to practice homœopathically, can afford to miss its meetings and the reading of its *Transactions*.

9. Beside my other writings, in 1886 I gave to the world a volume, entitled *Therapeutic Methods*, embracing the substance of my course in Philadelphia on the principles of medicine, and showing especially the scientific character of the homœopathic therapeutics. I am quite willing to be judged by the teachings of that work in all the years to come.

10. I have been an earnest advocate, by pen and tongue, of the rights of our school of practice, as against unfair legislation, instigated by members of the old school. And, more—I have been unalterably opposed to State censorship as to modes and means of healing, denying the right of the civil power to dictate in the premises.

I believe in the utmost freedom of the citizen while not a soldier, a convict, a lunatic, nor a pauper, to choose his own minister and means of relief from physical suffering, without governmental restriction or interference; and equally do I believe in the impossibility of any legally fixed standard of qualifications to be erected and enforced by police government. Each college and each society, or all the colleges and all the societies of any particular school, may have requirements and regulations to govern their own members, and to be respectfully regarded by their adherents; but let any or all forever abstain from a seizure of the legal arm, the governing power, to coerce and limit human efforts for the cure of the sick.

11. Among the greatest contributions made by me, aided by a faithful wife, to the cause of human healing has been in four sons, graduates in medicine—namely, William C., Walter M., Charles, and Frank B.—the first two now associated with me, the third located at Hot Springs, Ark., and the fourth lately at Chicago, now on leave for his health—all members of the American Institute of Homœopathy.

THE SOUND IN DYSURIA AND INCONTINENCE.

BY ALFRED HEATH, M.D., F.L.S., LONDON.

Miss W., aged 50, for fifteen or twenty years has been unable to pass her water freely. At times has to wait a quarter of an hour before she can pass it, although urgently needing to do so. While in the

act of passing it the water suddenly stops and then goes on again. Thinking she might have a stone, I passed a No. 8 steel sound into the bladder, but could find no stone. From the time the sound was passed, more than a month, she has had no difficulty whatever, the water passes perfectly freely and as if there had never been any trouble.

Mrs. P., age 40, for many years has been unable to retain her water when walking out of doors, if only a very short distance. About six weeks ago passed a No. 8 steel sound. Since then she has had no trouble, and can hold her water perfectly.

CORRESPONDENCE.

DR. BURNETT AND ANTHRACINUM.

EDITORS HAHNEMANNIAN:

Dr. J. Compton Burnett in his work entitled "New Cure for Consumption," in speaking of the introduction of anthracinum, says on p. 120, second edition, "Weber published his work recommending anthracin as a specific for anthrax at Leipsic in 1836 (*Der Milzbrand und dessen sicherstes Heilmittel*, von G. A. Weber), so this part of Pasteurism is really Weberism." It does not seem possible that Dr. Burnett should not be familiar with Hering's *Guiding Symptoms*, because he speaks, on p. 123, of Dr. S. Swan having probably received his first ideas in regard to *tuberculinum* from lux through C. Hering, and yet he must have overlooked the facts as stated by Hering in his preface to anthracinum, that directions were given by him in Stapf's Archives, in 1830, how to prepare the virus, which directions were carried out by *Dr. G. A. Weber*, and that he applied the remedy "with the most astonishing success in the cattle plague. He cured every case with it and also men poisoned by the contagium. His report, a small treatise of 114 pages, was published in 1836 by Reclam, Leipzig."

So this part of Pasteurism is really *Heringism*.

CHAS. B. GILBERT, M.D.,
Washington, D. C.

EDITORIAL.

OUR MISTAKES.

ABOUT ten or a dozen years ago the *British Medical Journal* started a new department which was called "The Confessional." In it was intended to be chronicled physicians' errors, that their colleagues might profit by the same. We recall a case that was then reported, that of a death from puerperal fever arising directly from the use of a pair of obstetrical forceps that had not been properly cleaned and disinfected. "The Confessional" did not thrive, for, so far as we can learn, it was not continued very long. Either physicians were not willing to acknowledge their errors, or else they had attained so near perfection as to make no mistakes; or, a still more horrible alternative, they never knew when they were wrong. It takes a brave man to acknowledge error; and so "The Confessional" failed of contributors.

Our attention has been directed to this subject of mistakes by the first instalment of a paper on the subject by Dr. William Murray, published in *The Lancet* for May 7, 1892. The author very properly says, that "the man who makes no mistakes seldom or never does anything worthy of note." We would further add, that he who, in deciding important questions, decides correctly in over seventy-five per cent. of cases, may be regarded as a successful man. We profit by experience, is an old saying, but experience will do little for us until we acquire not only the ability to learn when we are in the wrong, but also a spirit of fair-mindedness which shall lead us to acknowledge our errors. If we remain persistently blind to our mistakes, we must expect to be relegated to the company of professional fossils and ignoramuses. The man whom we entertain as one of the highest in his professional attainments is also one who has the most frequently said to us, "I do not know," or acknowledged mistakes. The dogmatists, the egotists, and others of like ilk, who are never wrong, who never fail in their undertakings, are men to be avoided. Success should not so elate us as to lead us to ignore the possibility of our having done even better under the circumstances. If it does, then that success is a misfortune. Dr. Murray, in his paper, refers to a great general who was once found making a careful survey of a field of battle which he had won. On being asked what he was doing, he said, "Studying my mistakes."

Dr. Murray divides our mistakes into three classes: 1. Those which can or ought to be avoided by every intelligent, well-taught, and experienced practitioner. 2. Those which can only be avoided by an unusual amount of experience and insight. 3. Those which no amount of experience or insight will enable us to avoid.

As to the first of these classes, every one of us, no matter how skilful he may be, or how generally systematically careful, is liable. A slight relaxation of even ordinary vigilance, long addiction to routine practice, lead to error. An amusing story is told of a great surgeon who was summoned to attend an injured leg. The wound was on the posterior aspect of the limb. It was of such a character as to lead the surgeon to recommend amputation as the only resource. The patient was anæsthetized. But, horror of horrors, on turning the patient over for operation, the legs changed sides, and the surgeon amputated the sound limb. The mistake became all the more serious when the injured limb recovered without operation. Surgical errors are always more serious than others. They are likewise the less frequently met with, the surgeon's training leading him to place his main reliance upon the evidence of his own senses, and less upon the statements of his patients. In general practice, the great danger seems to lie in the feeling that the physician is thoroughly conversant with the constitutional peculiarities of his patients. He neglects proper physical examinations; indeed, he may be forced to do so by his patients, who resent any investigation that gives rise to extra trouble. Do we not often hear of albuminurias that have not been recognized by thoroughly efficient practitioners? Do we not meet with menorrhagias that are soon found to be dependent upon irremediable cancer? Do we not note periods of malnutrition that precede serious neurasthenic states? After the case is over, and the post-mortem has been made, we may well look back at the case and ask ourselves if we have erred, and if we have learned the means which led to error, and those which will prevent a similar one in future.

We believe that the majority of preventable mistakes are of a most outrageous character; ones that the merest tyro should be able to avoid. Aside from those mentioned above as occurring in general practice, there are those which arise as a result of the very thoroughness with which the first examination of the case is conducted. The patient is examined physically, and an opinion is formed. Forever afterwards, or until another physical examination shows otherwise, every symptom appearing in that patient is made to fit in with

the opinion already formed. On the other hand, it should be our duty, as soon as any phenomenon inconsistent with our previous knowledge of the case turns up, to thoroughly investigate anew. We might say, that it is our duty to give our old cases thorough physical re-examinations at regular intervals. How often do we meet with success at the outset in managing a case. Improvement stops; and then, instead of starting all over again, we wander about aimlessly, trying methods which on mature deliberation we would not tolerate. An amusing though pardonable error recently came to our attention. An hysterical woman had tried the patience of her doctors and family for several months. Many were her symptoms, and loud were her complaints. Finally, she was sent to a hospital, where it was learned that she was seven months pregnant. Anybody knew enough to find this out; but why did they not do it? The patient had been having the greatest variety of symptoms, and as she had been examined time after time, and no physical explanation of her nervousness discovered, examinations were finally ignored, and all symptoms made to fit (even those of the pregnancy itself) the hysterical hypothesis. We recall an error of our own, made a number of years ago. We had been sent for to see a boy who had had a tooth extracted that day by a travelling dentist. He had severe facial pains, especially worse in the space from which the tooth had been removed. There was, apparently, an old fang left. We so diagnosed the case. But we were much discomfited the following day to learn that the supposed fang was a new tooth coming through, and that the pain was dependent upon a tooth in an entirely different portion of the mouth.

Avoidable mistakes are to be avoided only by study and systematic investigation of cases. Physical examination of the entire patient should be the rule. How can we learn that a slight soreness in the knee is due to a synovitis with effusion, unless we strip the patient? How many obscure symptoms receive thorough interpretation after an albuminuria has been discovered? How readily some cases are cured when the active cause is discovered and removed! And yet we can do nothing in any of these cases unless our methods are thorough.

Dr. Murray takes occasion to mention cancer as one of those complaints which it takes great care and insight to recognize in its early stages. The vast majority of gastric cancers are in their earlier stages diagnosed as functional dyspepsias. And this error is pardonable, for without physical evidence cancer cannot be diagnosed;

and until the growth has attained a certain size, physical signs are wanting.

As to the mistakes which are unavoidable, we must acknowledge their occurrence. At the same time we must recognize that, like the functional diseases, as our knowledge and experience increase, they become beautifully less.

As to the mistakes of others, let us be charitable. All of us make them. But to each physician's mistake about which we hear, there are a score of successes by the same man which never come to our attention.

As to our own, be thoroughly conversant. Learn the why and wherefore, and how they could have been prevented; and then see to it that they never occur again. Do not be afraid to learn of your errors, for none are so ignorant as those who do not know when they are wrong.

THE AMERICAN INSTITUTE OF HOMŒOPATHY.

THE Washington meeting of the Institute convening June 13, 1892, will be one of the most important in the history of homœopathy and the issues involved claim the attendance of every homœopathic physician in the United States who is loyal to the interests of the school. The scientific feature of the meeting will be strongly represented and maintained at the usual high standard of the Institute. The opportunity and necessity of showing the governmental officials the unrecognized strength and importance of our school demand an unusually large attendance of members and delegates and at least one thousand physicians of the scientific school of medicine should be present during the four days' sessions.

The various schemes of the old school of medicine to destroy professional liberty must be met boldly and handled in a manner that will make these enemies of medical freedom beware how they proceed with their nefarious work.

This meeting will afford ample opportunity for physicians of the same State to come together and discuss informally the measures best to be adopted in their respective States to place homœopathy on a firm basis, and to have their States recognize the school by appointments in the distribution of public medical patronage. For instance, the State Society of Pennsylvania will meet September next, when two great questions of vital importance to homœopathy in this State must come up for consideration and action. First. The establishment of a Board of Medical Examiners, and secondly, the subject of public provision for the insane desiring homœopathic care. At

the Washington meeting the Pennsylvania members can readily find an opportunity, and should come together and discuss these subjects. An interchange of views will have great influence in shaping these questions so that they may be properly adjusted next September. The same holds good with all other States and will prove to be a positive influence in the service of homœopathy.

The membership of the Institute is not as large as it should be; three hundred new members ought to be admitted this year. The president and secretary of local and State societies should make it their duty to call the attention of their members to the necessity of their joining the American society and solicit, personally, applications for membership in the Institute. Blank applications can be secured from Dr. Dudley, the general secretary.

The Local Committee of Arrangements has given extraordinary attention to perfecting plans necessary to make this meeting a sure success. They are looking for at least two thousand members and visitors and are fully prepared to take care of this number. For details of preparation, see page 87, *News and Advertiser*.

THE RETIREMENT OF DR. DILLOW.

JUST as we go to press, we receive the May number of the *North American Journal of Homœopathy*, from which we glean the information that Dr. Dillow has resigned his editorship of that journal, and that he will be succeeded by Dr. E. H. Porter. We regret to learn this, as Dr. Dillow's management of the *North American Journal* has made it the valuable journal it is. For seven years he has worked in the editorial chair; and his administration has ever shown evidence of his ability. While thus speaking of the retiring one, we can speak equally well of his successor, Dr. Porter, who, though he be "new" as the editor of the *North American Journal of Homœopathy*, is by no means "new" as an editorial worker. We expect to find in him a man in every way fitted to be at the head of a leading journal of a great school of medicine.

A CORRECTION.

A FEW months ago, when reviewing the address of Dr. John B. Roberts, we misrepresented the attitude of the Philadelphia Polyclinic to homœopathic graduates. We have since learned that graduates from our college have been accepted as students, and that this fact is stated openly and "above board" in the announcements of the institution for at least two years past.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D.,

FRANK H. PRITCHARD, M.D., AND EDWARD M. GRAMM, M.D.

DELIRIUM TREMENS.—Dr. H. Krukenburg, of Hamburg, Germany, has made an exhaustive study of this subject. Amongst the lower classes in Hamburg there is an extensive abuse of alcoholic drinks, and especially that of brandy. The new hospital at Hamburg-Eppendorf has a special department for the treatment of alcoholism. The number of cases treated in 1891 was 301, which consist of 265 patients, with 36 relapses. Of these patients 119 were cases which had been treated the year before; hence there was a percentage of 45 of relapses. Some of these even relapsed 27 times. The diagnosis was:

	Cases.	Relapses.
Delirium tremens,	148	13
Chronic alcoholism,	103	...
Acute alcoholic intoxication,	6	...
Other alcoholic psychoses,	5	...

The patients were nearly exclusively men, between thirty and forty years; only three patients were over seventy. Restaurant keepers, waiters and such persons form the majority. The patients from the upper classes are usually in reduced circumstances. Only six women were observed. Prostitutes were not allowed to enter. In nearly every case brandy, which is drunken together with beer in equal parts, was the beverage; from one-half to two quarts of brandy was the daily amount. Beer is rarely, if ever the cause. The patients' statements in such cases were absolutely unreliable. The quantity of alcohol drunk does not bear any relation to the outbreak of the disease. One hundred and seven patients were ventropathically predisposed; in 144 cases the relations suffered from psychoses, epilepsy, or were habitual drunkards. Twenty per cent. had drunken fathers; how far this predisposes the writer leaves unsolved. Six cases had passed through serious diseases before. Immediate causes play a great part. Sudden leaving off the habit could in no case be proven as a cause, which the writer emphasizes, for it is generally believed that alcohol must be supplied to drinkers in order to keep off delirium when attacked by this or that disease. No delirious patient was given alcohol after his entrance. Most of them soon quiet down of their own accord. Alcohol was only administered where such complications as pneumonia, etc., with threatening collapse, set in, and then in large doses and in a concentrated form. Delirium, due to abstinence, as in morphiomania, is not recognized by the writer; the use of alcohol is unnecessary in treatment. The history of the case was never obtained from the patient but from his relatives and friends. In this manner of 143 cases, about 50 per cent. could be traced to an immediate cause. In twenty-three cases an acute infectious disease, and of these twenty were pneumonia, brought it on; in fourteen cases violent excesses, in fifteen cases grave injuries, in nine spontaneous internal hemorrhages, consumption, iritis, furuncles, gastritis. In seventy-four no exciting cause could be discovered. The writer then passes the symptoms in review. The hallucinations of vision are dependent upon the patient's surroundings, and one often finds them not to be hallucinations, but rather illusions. Sight is normal during these, as the writer has often proved. Their imperative ideas may be explained in the same manner. They are not hallucinations but psychic illusions provoked by misunderstanding their relations and surroundings. One of the patients was tortured by the thought that he was to be castrated. Investigation showed him to have shortly before been suffering from a chancre. Self-mutilation is rarely seen. Relapses do not present anything peculiar; an entire series of attacks will not necessarily leave behind them any serious consequences. On the contrary, extensive trophic and somatic changes may yield to continuous abstinence. The writer's

observations show a mortality of 10 per cent., other authors place it between 5 per cent. and 24.30 per cent. This favorable mortality rate demonstrates that one need not fear the appearance of fatal collapses, if one deprive the patient of alcohol, a therapeutic measure which has been practiced during last year in this institution. Out of twenty cases complicated with pneumonia, nine died. Alcoholism plays, as is well known, an important part in the mortality of pneumonia. Tuberculosis seems to exercise a similar influence. In a number of patients, who were discharged as cured, incipient pulmonary tuberculosis could be diagnosed. This point is worthy of notice, especially as lately, cirrhosis of the liver has been observed associated with peritoneal tuberculosis. Hence it is clear that alcoholism increases the predisposition for tuberculosis, which fact is to be borne in mind in the treatment of phthisis. In old people delirium tremens sometimes runs into chronic dementia. The sensory disturbances are dependent upon neurotic changes, and are either functional or purely psychic, as for example, the analgesia. The delirium lays hold of the patient and keeps his entire attention; he knows neither pain, hunger, nor fatigue. Ophthalmoscopic examination reveals nothing during and after the attack. Only in some cases did he find the retinal arteries contracted and the veins fuller. The patient's vision, in strength, undergoes no changes; on the contrary, his field of vision is subject to peculiar changes. In nineteen delirious patients, twelve presented great concentric narrowing of the visual field, in five slight and in two none was noticed. A concentric contraction for color perception also is remarked, which in some cases disappears before the former symptom does. The limits for red and blue overstep the normal boundaries again to return to the normal. There is transitory anæsthesia of the retina, similar to that found by French investigators in hysteria, and by Oppenheim and Thomsen in epilepsy and other psychoses; a large number of these alcoholic individuals suffer from epilepsy, about 35 per cent. of 200 patients in the writer's observations. The above mentioned ocular symptoms are also found in non-epileptic delirious patients, and again they may be wanting. There is a resemblance between these patients and epileptics. Out of the relapsing cases, forty-four, 16 per cent. were epileptic. Their epileptic attacks are completely identical with those of true epilepsy, with its aura, etc. It never appears in abstinent patients, but is associated with other alcoholic phenomena. Delirium tremens and the motor attack belong together, as do the epileptic mental state and the spasmodic attack. The spasm must be regarded as the beginning and not the cause of delirium tremens.

Pathologically there are revealed, at the necropsy, increased proliferation of tissue, turgescence and opacity of the pia mater, the result of the frequently recurring venous stasis. The brains of delirious patients present nothing of peculiar anatomical interest. The clinical phenomena are all that one has to base one's decision on the gravity of the disease. These present great similarity with epileptic states, without absolutely identifying the two affections.

A slow pulse is characteristic of alcoholism; in delirium tremens the pulse is dicrotic. In delirium tremens there is never retention of urine, which may be used as a differential diagnostic sign between it and meningitis, which delirium tremens, complicated by a pulmonary affection, might easily simulate, and mislead one. In 37 per cent. of the hospital cases of alcoholism, albuminuria was present; in 52 per cent. of those delirious, oliguria sets in to pass into polyuria, without albumin.—*Norsk Magazin for Lægevidenskaben*, No. 4, 1892.

SYPHILITIC SPINAL PARALYSIS.—Professor W. Erb, of Heidelberg, Germany, has for years observed in persons who had been infected with syphilis, certain forms of spinal disease, which, on account of their resemblance to certain well known similar and allied diseases, and, again, their characteristic difference, are worthy of more exact clinical study. This affection is characterized by the appearance of paræsthesiæ, later, pronounced spastic paresis, and rarely paraplegia. Weeks, months, and even years are required for its development. The patient has an exquisitely spastic gait, with but slight muscular tension and contracture. The patellar reflex is, on the contrary, distinctly augmented. Disturbances of sensation are usually slight and often with difficulty demonstrable. Weakness of the bladder and decrease of the sexual appetite are generally present. Muscular atrophy is absent in the majority of cases. Electric excitability remains unaltered. The upper half of the body is entirely normal. The course of the disease shows an undoubted tendency towards improvement; energetic treatment, especially, so restores the patient that he is enabled to resume his occupation, etc. The clinical picture

is so characteristic that Erb diagnosticates the case as of syphilitic origin, before asking whether this disease has preceded. It is easily diagnosticated from the other chronic spinal diseases, as tabes dorsalis, multiple sclerosis, myelitis from compression and myelitis. It is at once distinguished from spastic spinal paralysis with which it is strikingly similar, by the presence of sensory disturbances and vesical weakness, without considering the strikingly slight muscular rigidity, as well as the difference in its origin and course. Transverse dorsal myelitis is differentiated with more difficulty, yet the syphilitic form presents certain peculiarities, for example, the patients do not become entirely paraplegic or, if they do, they recover so that they are able to be up and about. Further, the relatively slight disturbance of sensibility which are often sharply limited on the upper portion of the body and the unpronounced muscular rigidity, are of service in the differential diagnosis. It is more easily distinguished from other syphilitic spinal and cerebral affections, as well as from syphilitic multiple neuritis of the peripheral nerves. The dependence of this disease upon preceding syphilitic infection is proved, not only by its being observed in formerly syphilitic individuals, in whose cases no other causes could be proved and where there was a certain near connection between the preceding infection and the spinal disease—generally three to six years. It is much rarer than tabes dorsalis. The affection seems localized in the dorsal cord and is systematically situated in the posterior portions of the lateral columns. From here it extends to the gray and white posterior columns. The lesion is partly a syphilitic infiltration and partly a myelitic alteration, due to syphilitic disease of the arteries—degeneration. The writer regards himself justified in setting this apart as a separate affection on account of its relative frequency of appearance and symptomatic uniformity.—*Wiener Med. Presse*, No. 16, 1892.

THE EFFECTS OF INJECTIONS OF THE JUICE OF THE THYROID GLAND.—Dr. George R. Murray has been making experiments to determine the effects of hypodermic injection of the juice of the thyroid gland in myxœdema and allied conditions. As is well known, the removal of the entire thyroid gland from man is followed by a species of cretinoid condition. If, at the time of operation, care be taken to leave even a small fragment of the thyroid behind, this bad effect does not follow. Following the suggestion of Victor Hersley, Bettencourt and Serrano, of Lisbon, introduced one-half of the thyroid gland of a sheep beneath the skin of the infra-mammary region in a woman of 36, suffering from myxœdema. Relief was immediate. In fact, the very rapidity of the improvement suggested that it could not have followed, because the gland had become vascularized and so functional, but from absorption of the juices of the healthy thyroid gland by the tissues of the patient. Dr. Murray therefore determined to try the effect of the thyroid juice in a case of myxœdema under his care. Under treatment the patient improved steadily. Menstruation and perspiration, which had been absent for over four years, returned. The swelling of the body steadily diminished; speech became more fluent and lost its drawl; the mind became more active and memory has improved.—*British Medical Journal*, October 10, 1891.

In the *Comptes rendus de la Société de Biologie* for April 24th we find an account of M. Gley's intravenous injections of the juice obtained from triturating thyroid glands. As is known, the extirpation of the thyroid gland in dogs causes grave convulsive attacks, which are soon followed by death. Healthy dogs, with their thyroids intact, present nothing remarkable after the injection of the juice mentioned; those, however, that have just undergone extirpation of the thyroid and are beginning to be the subjects of general convulsions, are very much relieved, and in some cases saved from death by having an intravenous injection of the juice obtained from both lobes of the thyroid. It is stated that even within twenty-four hours after the extirpation of the gland, when the animal begins to show a stumbling gait and even incapability of maintaining the upright attitude, when there are violent and incessant contractions of all the muscles, with marked polypnoea, etc., an injection of the juice of the thyroid causes a favorable change within a few minutes. The intensely convulsive fits begin to diminish and soon disappear completely, the respirations resume their normal rhythm, the paralysis of the extremities disappears, etc. As a rule, the unfortunate train of symptoms reappears the next day after the injection, but a second injection aborts them very readily. The injections were found to be inefficacious only when given too long after the extirpation of the thyroid gland; otherwise they always acted successfully. The same results are obtained from the glands of animals of different species.—*New York Medical Journal*, November 28, 1891.

QUANTITATIVE TESTS FOR UREA.—Dr. J. C. Bierwith has been making experiments to determine the relative accuracy of the different apparatus and methods advocated for the ready estimation of the quantity of urea in the urine. His results show that of the apparatus in the market, that designed by Doremus is the only one that can be considered reliable, and at the same time fit for the practical physician. The hypobromite of soda solution is the only one that should be used. Tests made with chlorinated soda, or with chlorinated soda and a 20 per cent. solution of bromide of potassium, are unreliable, the former chemical as found on the market being of such variable composition. If the hypobromite of soda solution is used, it should not be kept too long, as it deteriorates readily. The author thinks that it does not retain its virtues after one month; and, even then, should be kept in glass-stoppered bottles with paraffine. (The hypobromite solution may be made as follows: Take of caustic soda 100 grammes: water, 250 c. c.; bromine, 25 c. c. Dissolve the soda in the water, and when cold add the bromine and mix well; then add sufficient water to make the entire mixture up to 500 c. c.) Owing to the instability of the hypobromite solution, the soda solution may be made up alone. Then, in making the test, the ureometer may be filled to the mark on the reverse side of the instrument with the soda solution, after which 1 c. c. of bromine may be added. Then the bulb should be filled with water and the tests proceed as before. *New York Medical Journal*, November 21, 1891.

[We have employed this little apparatus of Doremus' with great satisfaction. It is inexpensive and neat, and the test may be made within a very few minutes. The only objection to it is the handling of the bromine, which can be readily overcome after a little experience.—Eds.]

DIAGNOSIS OF INCIPIENT TABES DORSALIS.—Prof. Fournier, of Paris, has made a study of this disease in its incipency. While it is easily diagnosed when it is well developed, the contrary is quite true in its incipency. Examination of the gait and the reflexes is quite insufficient, and finer methods must be employed. They are as follows:

1. Westphal's sign, absence of the patellar reflex, is present in about three-fourths of the cases in the pre-atactic stage.

2. Romberg's sign, which, in advanced stages, consists of swaying movements, total loss of the power of equilibrium, and danger of falling when the patient stands with closed eyes, is brought out if one allow the patient to stand, first, a few minutes with closed eyes, and then have him bend either forwards or backwards, to the side, etc. Sometimes one must wait two or three seconds in order to develop this, but the practiced eye will often detect distinct swaying of the trunk of the body. This muscular inco-ordination is deserving of great attention, as it is often the first symptom of disturbed co-ordination.

3. Difficulty in going down stairs is often one of the most regular and sometimes the first sign of ataxia. Patients go down stairs with great care, holding on to the ladder, fearing that they may fall, which would no doubt happen were they without support.

4. Crossing the legs, for example, in sitting, is not done by an atactic in the same manner as a normal person. An atactic throws his leg out over his knee, describing a broad circle. In many patients, the manner in which they seat themselves in an easy chair is significant of tabes.

5. Marching at command may be divided into three parts. If one ask the patient to arise and to set himself immediately in motion, he thinks it over a moment before doing so. There is a short pause between the rising and the first step, or on rising there is a slight swaying, and accessory movements are necessary. If one have him walk off and tell him to halt as soon as he is commanded, he will stop with a slight indecision, a swaying, a slight quaking, often with a slight backward or forward movement of the body, while the well person stops at once. If one ask the patient, while walking, to turn suddenly about, he will manifest a slight indecision, embarrassment, a faulty position, or, in some cases, threatening to fall.

6. Standing on one foot is the most sensitive sign of all, and if one blindfold him he will then exhibit the finest reaction, will sway from side to side, and even threaten to fall over or be obliged to give it up. All of these signs are not infallible, but are of great service in practice in the diagnosis of ataxia.—*Le Bulletin Medical*, No. 12, 1892.

THE ETIOLOGY OF NEURASTHENIA.—Dr. L. Joseph, of Landeck, Germany, finds that the usual chronic form of neurasthenia is due to continuous and long acting de-

bilitating influences. In women these are generally protracted and profuse menses chronic endometritis and vaginitis in cases where their exhausting influence is not equalized by an increased action of the digestive and assimilative organs. Hence conditions of exhaustion make their appearance, which lead to more or less faulty innervation in various parts of the organism. Neurasthenia may also be produced by a purely mechanical irritation of the genital sphere, with sexual excitement. The acute form, which is extremely rare, follows profuse and sudden hæmorrhages, which, on account of their threatening the patient's life, exercise a depressive psychic influence. These are liable to pass over into the chronic form and persist, even after the causal factor is removed.—*Wiener Med. Presse*, 1892.

PLEURITIS AS A COMPLICATION OF PERITYPHLITIS.—Dr. Wolbrecht claims pleuritis to be a frequent complication of perityphlitis. It may be overlooked by failing to examine the pleura in such cases. Among 89 cases of perityphlitis which he had observed, 34 were accompanied by pleuritis, *i.e.*, a proportion of 38 per cent. Peculiarly enough these cases all ended in recovery, while 40 out of the other 55 perished. Of these 19 were serous, 3 non-exudative and 2 purulent. One terminated by the formation of vomiceæ, while the other required a resection of the rib with evacuation of two and one-half litres of pus. Of the non-purulent variety 23 were right-sided and one on the left, the other three were double. The tendency is decidedly to attack the right side. According to the writer, the disease is due to extension of the pericæcal inflammation, by means of the peritonæum and retro-peritoneal connective tissue.—*Le Bulletin Médical*, No. 25, 1892.

PHLEBITIS COMPLICATING THE GRIPPE.—Dr. Rendu has observed three cases of phlebitis from grippe since last November. The last case presented the peculiarity of being a very slight attack, while the phlebitis itself was very intense. A colleague of the writer had, at the time, a case of phlebitis complicating the grippe, in a lady, sixty-eight years of age, under treatment.—*Le Bulletin Médical*, No. 25, 1892.

VENOUS ABDOMINAL SOUFFLE.—Drs. Audry and Periol have found in certain patients, especially young and chlorotic women, that, if one auscultate, during expiration, slightly above the umbilicus, one will perceive a venous souffle, similar to the bruit de diable of the jugular vein. Not all patients present this; it becomes less distinct during inspiration, on account of the abdominal walls pushing themselves outward.—*Le Bulletin Médical*, No. 24, 1892.

NOTE ON THE EXAMINATION OF URINE IN DISEASES OF WOMEN.—Dr. Clifford Mitchell says that it is now known that many cases of scant, delayed, or suppressed menstruation are far more frequently the result of nerve exhaustion than of uterine disease, and that many conditions heretofore ascribed to the baleful influence of the uterus are really to be referred to a neurosis. Now in the differential diagnosis, examination of the urine is not to be forgotten. Dr. Mitchell has yet to see a neurosis in which phosphoric acid in the urine is not diminished.—*Medical Era*, May, 1892.

THE NORMAL TEMPERATURE OF THE AGED.—Kelynack, of Manchester, has made some observations on healthy aged persons, which go to show that (1) the normal senile temperature, as registered both in the rectum and axilla, is very distinctly below that of healthy children and adults; (2) that the rectal or internal temperature in old age is almost always higher than the axillary, but varying from 0.2° to 1° F.—*Manchester Medical Chronicle*.

APPLICATION OF ICE TO THE SPINE IN THE TREATMENT OF ASTHMA.—Dr. B. O. Kinnear is an ardent advocate of the application of Chapman's ice-bags to the spine in the treatment of asthma, which he regards as a purely nervous affection. He does not particularize the *technique* of the treatment, but, from the reports of his cases, one gleans that the applications are made from the lower cervical or upper dorsal vertebræ downwards to the upper lumbar. The bags are to be kept *in situ* for periods of an hour or so at a time, and repeated three or four times daily in suitable cases. This treatment serves to equalize the general circulation, and to do away with the sufferings arising from other visceral neuroses which asthmatic patients are very apt to have. The first application frequently gives great relief to the paroxysm.—*N. Y. Medical Journal*, April 23, 1892.

PEROXIDE OF HYDROGEN IN GONORRHEEA.—Dr. B. W. Richardson recommends an injection of consisting of 10 vol. solution of the peroxide of hydrogen, one ounce; tannin, ten grains; distilled water, three ounces. In a case he records the discharge had entirely ceased within a week, and ten weeks afterward had not returned.—*Dublin Journal of Medical Science*, December, 1891.

URTICARIA FROM THE SULPHATE OF QUININE.—Dr. G. Lore, of Brolo, Italy, has observed several cases in the course of many years, and communicates in detail the history of one. The patient took 15 grains of the sulphate of quinine to abort an attack of intermittent fever. An hour after taking he noticed a universal burning and itching all over the body, especially noticeable upon the legs, forearms, and chest. There soon appeared a plentiful eruption of large, hard, and red blotches upon the hyperæmic skin (urticaria tuberosa). Notwithstanding this the patient took on till even the fourth dose, when the urticaria became much more intense and the pruritus of the whole body tortured him. The urticaria disappeared that same afternoon. The fever, however, was relieved. This salt was repeated some time after, with the same results. The bisulphate produced the same phenomena, but less accentuated. The sulphophenate of quinine also produced the same eruption. He has several times seen in a lady, after taking quinine, even in minute doses, tumefaction of the upper lip, with red spots and pain, more or less burning in character—erythema.—*Revista Clinica e Therapeutica*, No. 2, 1891.—Dr. V. Giampetro has recorded a similar case.—*Revista Clinica e Therapeutica*, No. 9, 1890.—*Journal of Cutan. and Genito-Urinary Diseases*, August, 1891.

PROPHYLAXIS OF THE GRIPPE.—Dr. Ollivier, of Paris, France, has found the use of cod liver oil to act as an efficient prophylitic in the grippe. A teaspoonful is given during the course of a meal. During the epidemic of 1890 he administered the oil to thirty children, while their brothers and sisters were given none; those to whom the oil was administered did not present a single case of the grippe, while those which were used as a control were attacked. It acts in the same manner in adults, children and men; during the present epidemic he has had but one case of grippe among those who have taken the remedy systematically. This patient was a tuberculous subject, in whom the disease ran a very wild course. To children he administered 1-4 teaspoonsful and to adults and old persons 2-3 soup-spoonsful are given, during the course of the first meal of the day. Taken in this manner, the oil does not provoke vomiting and is well borne.—*Le Bulletin Médical*, No. 10, 1892.

MASKED INTERMITTENT FEVER.—Professor von Krafttbebing, of Vienna, reports the following interesting case of masked intermittent fever; a young laborer, who suffered from mitral insufficiency, the consequence of articular rheumatism, but without neuropathic antecedents, or preceding alcoholic excesses, suffered from intermittent fever, which was at first of a tertian and then of a quartan type. Up to the day when he happened to fall into a canal during an attack of the fever and injured his head, he had had no convulsions nor delirium during the course of his fever or febrile paroxysms; but commencing with the fall, during which he contracted a slight contusion of the mastoid process on the right side, each fever attack was accompanied with symptoms of hystero-epilepsy, with hallucinations and delirium. The administration of quinine caused the nervous symptoms and then the fever to disappear. A relapse occurred which only yielded to the use of quinine and Fowler's solution in large doses.—*Wiener Medicinische Presse*, January 3, 1892.

TACHYCARDIA PROVOKED BY TRAUMATISM.—Dr. Le Dentu, of Paris, reports a case which shows that, among the causes of tachycardia, traumatism must also be kept in mind. Up to the present no such case has been reported. The case here in question was that of a coachman, 49 years of age, who, falling from his seat, struck upon his head and received a wound extending from the external orbital prominence to just posterior to the vertex on the right side, with denudation of the bone. The next day after the accident he was seized with an attack of tachycardia, his pulse running up to 200 and even 240 per minute. This condition lasted about twelve to fifteen hours, and was preceeded and followed by arrhythmia and cardiac intermittence. The temperature was but slightly elevated, and no sign of a cerebral or cardio-vascular lesion could be discovered. The patient also said that he had been subject to attacks of palpitation for some time. Hence one is justified in regarding the tachycardia, as well as the previous palpitation, as of purely nervous origin.—*La Semaine Médicale*, No. 7, 1892.

THE ADMINISTRATION OF COD-LIVER OIL AND HYPOPHOSPHITE OF LIME IN PHTHISIS.—Charteris, while agreeing with the majority who testify to the value of cod-liver oil and hypophosphite of lime in phthisis, says that the former should not be given by routine. To secure proper assimilation, it should be prescribed in a teaspoonful dose at bedtime for three successive nights, then a dessertspoonful at the same time. On the sixth and seventh days it should be taken a dessertspoonful after dinner and at bed-time, and afterwards in a tablespoonful dose after each meal. If so prescribed, it does not cause nausea or eructation, and the dose may be increased in accordance with the wishes of the patient until the end of the fifth week, when it should be stopped for a week and resumed. With each dose of the oil five grains of hypophosphite of lime, dissolved in a little hot water, should be taken. Thus administered, these medicines notably increase the strength of the patient, and returning health is evidenced by increased weight.—*The Lancet*, March 5, 1892.

TREATMENT OF GALL-STONE COLIC BY GLYCERINE.—Dr. Ferrand has presented a work on this subject to the French Academy of Medicine. His conclusions are as follows:

1. Glycerine, administered by the stomach, is absorbed unchanged by the lymphatics, especially by the vessels which run from the stomach to the hilus of the kidney and the gall-bladder. It is found even in the blood of the subhepatic veins.

2. It is a powerful cholagogue and a precious remedy in the treatment of gall-stone colic.

3. A relatively large dose (twenty to thirty grammes, one-half to one ounce), will bring the attack to an end.

4. A small dose (five to fifteen grammes, one and a quarter to four drachms), taken in a little alkaline water, will act as a prophylactic.

5. Glycerine, without being a lithotriptic, is the remedy, *par excellence*, in gall-stone colic.—*La Semaine Medicale*, No. 13, 1892.

PNEUMONIA WITH AN ERUPTION OF ROSEOLA.—Dr. H. Holsti reports the case of a man 24 years of age, who was attacked with croupous pneumonia of the lower lobe of the left lung, where a roseola-like eruption appeared on the upper portion of the chest and back. The eruption was of a brownish-red color, much resembling that of abdominal typhus, excepting that it was of a darker color and the blotches were somewhat larger. The pulmonary affection retrograded rapidly, and the eruption, which came out on the fourth day, quickly disappeared after a few days.—*Finska Läkaresällskap. Handl.*, bd. 32, p. 669.

ACUTE CIRCUMSCRIBED CUTANEOUS OEDEMA.—Dr. Nils Englund has observed six cases of this affection, which were all very similar. Without any premonitory symptoms of malaise the disease set in with slight rheumatoid pains in the joints, fever, pricking and pain in the region affected, which, excepting one case, was confined to the lower extremities. Suddenly there appeared a diffuse, circumscribed and uniform redness of the skin, with oedematous, doughy infiltration, which was elevated one or two millimetres above the surrounding skin. The affection showed no tendency to spread, neither did it recur. The oedema disappeared in ten, seven, fourteen, four and five days respectively.—*Nordiskt Medicinskt Arkiv*, No. 1, 1892.

PERMANGANATE OF POTASH AS AN ANTIDOTE TO PHOSPHORUS.—Dr. J. Hajnos, recalling the experiments of Dr. J. Antal, who recommended the permanganate of potash as an efficient antidote to phosphorus, used it in two cases with success. A young painter, 19 years of age, drank, December 23, 1891, a solution containing the heads of two packages of sulphur matches. After washing out the stomach the writer introduced 500 grammes of a $\frac{1}{5}$ per cent. solution of potassium permanganate into the stomach and permitted it to remain there; this was done one-half hour after the phosphorus was taken. The patient did not vomit, neither did he have any pain or disagreeable sensations, as nausea, etc. As the patient felt well the next day he was discharged. December 25, 1891, a gardener dissolved five bunches of sulphur matches in two decilitres of rum and drank the solution. The patient when seen was delirious and permitted no one to approach him; this was due, no doubt, to the alcohol drunk. He was bound down to his bed, his mouth forced open with a dilator, and a stomach tube introduced. Treatment as in the first case. After half an hour the patient vomited a portion of the solution, when he became somewhat quiet and fell asleep. Next morning there was slight nausea, yet he ate his

dinner with a good appetite. In a few days he left the hospital cured. In both cases the remedy was quickly applied and it exercised its full action.—*Wiener Medizinische Presse*, No. 15, 1892.

[Prof. Bokai, of Budapest, Hungary, in the *Bulletin Médical*, No. 100, 1891, first communicated this method of treating poisoning by phosphorus. The employment of turpentine and the salts of copper gave a mortality of 50-60 per cent. The experimenter has found a solution of the permanganate of potash, two to five grains, or thirty grains to one and a half drachms, in one thousand parts water, to form a chemical antidote. The oxygen of this compound unites with the phosphorus to form ortho-phosphoric acid, which is non-poisonous. The same reaction takes place in the stomach. Experiments on dogs have demonstrated the efficacy of this treatment. Those treated by this method, after poisoning by large doses, recovered, while those used to control the experiment all perished.—*Eds.*]

DIABETES MELLITUS EXCITED BY FRIGHT—The onset of acute glycosuria after mental trouble has recently been commented upon, severe emotional disturbances in some cases being looked upon as the cause of sugar excretion. The following case, related by Teschemacher (*Berlin. Klin. Wochenschr.*, No. 2, 1892), is an illustration of this point. The patient was a delicate boy, 7 years of age, who had gone through an attack of measles some months previously. Convalescence was very slow, and, on account of nocturnal incontinence, the urine was examined, and found to contain 4 per cent. of sugar. The child was hereditarily predisposed to diabetes, an aunt having died in early life of the disease. Some months later the patient was sent to Neuenahr. The quantity of sugar then present was 1.9 per cent., but after eight days of treatment with restricted diet it fell to .35 per cent. Bread was then allowed, and in a further period of eight days the sugar had entirely disappeared, and it was likewise absent some days later. Milk was then added to the diet. On the following day the mother sent the boy, who had hitherto not been allowed out of sight, to the post with a letter. On the way he was attacked by a dog, which sprang at him, and he fell to the ground, where he lay half unconscious with terror. He was carried home and put to bed. Trembling at first and speechless, he lay in bed for some hours before he partook of food, while he repeatedly asked for drink. Next day he was brought to Teschemacher, who examined the urine, and was astonished to find 3.3 per cent. of sugar. According to the mother, the quantity of urine passed was increased. Restricted diet was again ordered. On the following day the sugar stood at 2.4 per cent., two days later at only 15 per cent., and at the end of eight days it had completely disappeared. This case furnishes a striking example of the relapse of glycosuria after great mental excitement. Dietetic errors were strongly denied by the mother, and the ingestion of milk once in measured quantity could not have led to it, as the amount of sugar passed was greatly in excess of the lactose in the milk.—*The Practitioner*, May, 1892.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

TREATMENT OF EMPYEMA.—S. Evans (*Lancet Clinic*) states that the surgical treatment of empyema should be undertaken as follows:

1. *Thoracentesis*, i.e., evacuation by means of the trocar, with or without aspiration. This method is indicated when the empyema is due to the pneumococcus; in other words, is metapneumonic. It is worth remembering, that these cases are most frequent in children. Cures, rapid and final, frequently follow aspiration when dependent on this cause.

2. *Syphon Drainage.*—Bülan's operation, which consists of the introduction through a large trocar of a drainage-tube, the outer end of which is placed in a depressed bichloride solution. It is claimed that the negative pressure of the pleural space is maintained, and that the lung is prevented from retracting; besides, no air is admitted during the operation. This method is indicated in double empyemata, and in those metapneumonic cases in which one or more aspirations have failed.

3. *Pleurotomy*, with or without resection of one or two ribs, and permanent drainage, gives the best results in the great majority of cases; and, in almost any case, offers the best chance of a complete and speedy cure. It is particularly indicated when the cause of suppuration is the streptococcus instead of the pneumococcus. The point of election is in the sixth or seventh intercostal space in the axillary line; the upper border of the lower rib should be hugged in making the pleural incision, and the fluid should be evacuated slowly. Resection of one or more ribs gives better drainage, better access, and encourages collapse of the thorax.

When a fistula or a cavity persists, which occurs particularly in neglected cases, those of insidious onset (a serous, gradually becoming a purulent pleurisy), and those in which tubercle-bacilli are present, more radical treatment becomes necessary to relieve what may be termed *inveterate empyema*. The chest-wall must be made to meet the unexpanded lung, unexpanded because of the enormously thickened visceral layer of the pleura. This may be accomplished by one of two operations:

4. *Estlander's Operation*, i.e., a resection of several ribs, beginning in the axilla as the apex of a triangle, and going downward toward the base. Several transverse incisions are necessary, through each of which two ribs are resected; all the incisions are closed except the lowest which is used for drainage.

5. *Schede's Operation*, i.e., laying back a V- or H-shaped flap of the soft parts; sub-periosteal resection of the ribs, as extensive as necessary; excision of the thickened pleura over an area corresponding with the resection; suture of the flaps with drainage. Fever, tuberculosis, streptococci, amyloid degeneration, and persistence of a cavity are indications rather than contraindications for these operations.

A bacteriological examination of the pus aspirated, in making a diagnosis, is of great value as a means of deciding on the operative procedure to be followed and the ultimate prognosis.

[In eleven cases treated by pleurotomy, rib resection, and permanent drainage through an antiseptic absorbent filter, the only death has been in one of extensive lung gangrene and tuberculosis in a cachectic Hungarian, who was almost moribund, but revived and lived several weeks after the operation. The other cases, although apparently desperate, improved at once, and made complete and rapid recoveries.—Eds.]

A NEW METHOD OF INTESTINAL SUTURE.—H. W. Maunsell (New Zealand) has devised and practised a unique plan of carrying out *circular enterorrhaphy*.

The two ends of the intestinal tubes after resection are brought together by two "temporary sutures" through all the coats, one at the mesenteric junction and the other exactly opposite. The ends of the sutures are not cut short. A longitudinal incision one and a half inches in length is made by pinching up and transfixing the larger intestinal tube about an inch from its severed end. The "temporary sutures" are passed into the bowel and out through this longitudinal incision; by traction on these sutures the free ends of the bowel are drawn out of this opening. Some ten sutures are then passed through both sides of the bowel, taking a good grip of about a quarter of an inch, hooked up in the intestinal lumen and tied on both sides, thus making twenty interrupted stitches, with the knots inside. The "temporary sutures" are cut short and the bowel pulled back. The longitudinal slit is closed by a continuous suture.

In irreducible invaginations the intussusceptum is drawn out of a similar slit in the intussusciptum, its neck is transfixed with two "temporary sutures," and it is amputated a quarter of an inch clear of the stitches: these prevent retraction and preserve the proper relative position of the different bowel layers. The ends are sewed up and pulled back, and the longitudinal slit closed as before.

Marked disparity in the lumen of the two ends of the bowel can be overcome by removing a V-shaped piece from the larger and suturing the two sides.

Pylorotomy.—After excision, two sutures are applied to the duodenum and to the gastric opening at distances corresponding to the lumen of the intestine; a third suture is applied at the end of the larger opening in the stomach. The three "temporary sutures" are drawn through a longitudinal slit made in the stomach at a short distance from the resection; the edges of the stomach between the third suture and the one applied to the duodenum are united, and then the intestine and the stomach are stitched together between the two remaining sutures as above; the gut is drawn back and the longitudinal slit closed.

When excision is impossible, gastro-jejunostomy can be performed, as follows:

Openings of about an inch in length are made in the jejunum and the greater

curvature (anterior) of the stomach; they are united by a temporary suture at each end. A longitudinal slit is made in the anterior surface of the stomach, through which these openings are invaginated, sewed together and pulled back. The latter is then closed.

The same method may be practiced to perform ileo-colostomy, or lateral anastomosis of the ileum and colon, for obstruction or disease about the caput coli. It may also be used to implant the cut end of the ileum into the colon at any point, or even into the sigmoid flexure.—*American Journal of the Medical Sciences.*

DEATH FROM COCAINE.—Berger (Paris) reports a fatal accident with cocaine. A recent hydrocele, of two months' standing, was emptied, a couple of tablespoonsful of a 2 per cent. cocaine solution were injected, allowed to remain in the sac for a minute, then withdrawn, and followed by the ordinary iodine injection. The patient left the clinic, but returned in twenty minutes on account of feeling badly. He became comatose, the face and extremities were convulsed and the pupils dilated; then followed tetanic rigidity, the body being bent to the right, and death, in fifteen minutes, from cardiac failure. The autopsy revealed general congestion of the meninges and lungs, alcoholic lesions, *i.e.*, adhesions between the liver and diaphragm, and a mitral insufficiency. These lesions may be of value in explaining the cause of the fatal poisoning, the dose being not an excessive one (?); the recent character of the hydrocele, which favored absorption; the mitral insufficiency, which increased the susceptibility of the heart; the hepatic adhesions, which may have interfered with the elimination of the poison.

In the discussion that followed it was shown that the dose administered in this case was a dangerous one (about five grains). For subcutaneous use about the face and trunk one grain is the limit of safety; in the extremities, or where the Esmarch band can be used, a larger dose may be safely employed. The smallest fatal dose known is three grains; hence, allowing for idiosyncrasies, one and a half to two grains may be injected into the tunica vaginalis. Especial care should be taken with alcoholics and those affected with heart disease. The use of cocaine about the mouth and throat is especially dangerous. It is safer to employ weak solutions, 2 or 1 per cent. being the preferable strengths; an equal amount of the drug thus diluted is less likely to produce symptoms than when administered in more concentrated form.—*Revue de Chirurgie.*

[We have found it a safe rule in practice to use 2 per cent. solutions under the skin, of which never more than one drachm is injected; when greater strengths are required, 4 and 8 per cent. solutions are used, of which, in each instance, *less* than one-half the quantity is employed. Suspended in liquid cosmoline, two drachms of a 2 per cent. solution can be safely applied to mucous membranes; so, too, *less* than one drachm of a 4 per cent., and *less* than one-half drachm of an 8 per cent. solution. In the tunica vaginalis a half-ounce of a 1 per cent. solution is safe and efficacious.—EDS.]

HIP JOINT AMPUTATION.—Davy (London) reports ten amputations at the hip for intractable morbus coxae, with two deaths (20 per cent). The two fatalities were in adults, who also do not stand resection well; four others had previously undergone resection, subsequently standing the amputation better. Two have since died, eight and eleven years after the operation. In all the cases but one the rectal lever was used for hæmostasis; the elastic band, however, applied as a spica, and with due care to abdominal respiration, will answer every purpose. The method employed was that of Furneaux Jordan; The soft parts are divided down to the bone at the junction of the upper and middle third of the thigh and the vessels ligated. An incision is then made on the outer side, exposing the bone, and using the extremity as a lever, the muscles about the joint are divided successively and the head dislocated.—*London Lancet.*

TREATMENT OF MYXŒDEMA.—Murray (Newcastle-on-Tyne) reports a case of myxœdema successfully treated with injections of an extract of the thyroid gland of sheep. He was led to try this by observations of Bettencourt and Serrano and experiments of Vessale. The former found improvement within twenty-four hours after transplanting half a sheep's thyroid under the skin, and, as the gland could not have become vascularized and hence functional in such a short time, they inferred that absorption of the juice was the cause of the improvement. The latter obtained beneficial results, after thyroidectomy in dogs, by intravenous injections of thyroid extract.

The method practised by the author is as follows :

One lobe of the thyroid of a sheep is removed as soon as possible after the animal is killed, and cleared of its fat and connective tissue. It is cut into small pieces and placed in a test tube with one cubic centimetre each of pure glycerine and 5 per cent. carbolic solution; the tube is plugged with absorbent cotton and allowed to stand in a cool place for twenty-four hours. The mixture (three cubic centimetres) is then squeezed through a fine handkerchief that has been soaked in boiling water, and put in a glass stoppered bottle, where it will keep fresh for at least a week. All the instruments, dishes, etc., are to be thoroughly sterilized. One and a half cubic centimetres of the mixture are injected by means of a sterilized hypodermic syringe in the loose skin of the back, which has also been previously rendered aseptic. After a time the injections may be made less frequently, but they must be continued indefinitely, at intervals of two or three weeks, to keep up the improvement.

The patient, a female, 46 years of age, presented the characteristic symptoms of myxœdema: blank expression, thickened features, enlarged hands and feet; dry skin (no perspiration for four years), with shedding of the epidermis and hair; slow speech and movements, and loss of memory; languor, sensitiveness to cold, subnormal temperature; amenorrhœa (menstruated but once in four years); no thyroid could be made out; the urine was normal. Extracts of five lobes of the thyroid were injected during three months, the interval between the injections being gradually increased to three weeks. The skin swellings diminished; speech, memory and activity improved; menstruation became normal; perspiration returned, with decreased dryness of the skin; the sensitiveness to cold disappeared, and, when the temperature was taken, it was normal.

Beatty (Dublin) reports an interesting case:

Female, age 45, suffered from progressing manifestations of myxœdema for four or five years. The symptoms were lassitude, irritability, impaired memory, difficult locomotion, sensitiveness to cold. The face, tongue, hands and feet were characteristically enlarged; the skin was dry and the hair thin; the menses were irregular, the heart sounds and urine normal, and the hæmoglobin decreased 30 per cent. Massage was tried for six weeks, with some improvement, when injections of extract of thyroid were undertaken as described by Murray. Five thyroid glands were used, each in three injections during a week, at intervals of from four to seven days, for two months. The patient was practically cured, and the case could not be recognized any more as one of myxœdema. The face, tongue, hands and feet became natural; the movements, articulation and memory active; the hair began to grow thickly, and menstruation became normal.

Carter adds another case:

A female, 40 years of age, was admitted to the Lancashire County Asylum, in 1887, for insanity, symptoms of myxœdema being noted at the time. In 1891 the symptoms of the latter disease were, the characteristic face, hands, and feet; clumsy movements, slow speech; dry skin and scanty, dry hair; amenorrhœa for more than a year; normal urine, respiratory and heart sounds; no thyroid perceptible. Injections of thyroid juice from young pigs were made twice a week for three and a half months. Improvement began after the fourth injection, and continued until none of the characteristic symptoms were present. The mental condition too was modified, but a partial dementia persisted.

The technique of Murray was modified somewhat:

A piece of the gland as large as a damson plum, was cut up and put in a mortar with some bits of glass; half a drachm of glycerine and a drop or two of 5 per cent. carbolic solution were added. The mixture was ground to a fine paste which was allowed to settle in a test tube for twenty-four hours; the clear, dark-red fluid on top was decanted off and filtered through linen. In spite of strict antiseptic precautions, one of the injections was followed by rigor, septic fever, and local manifestations which lasted several days.

Fenwick (London), has found that thyroid juice possesses a distinct diuretic action in diseases of the kidney, though apparently it is negative in healthy persons. He split the thyroid of a sheep, and before fixing it under the skin, in a case of myxœdema, rubbed the glairy secretion that oozed from the cut section into the subcutaneous tissue. The following day the temperature rose to normal, and the amount of urine increased from twenty to fifty ounces. In another case hypodermic injections of an extract of thyroid produced similar results.

He removes the gland from a freshly-killed animal, splits it, mixes ten drops of

the expressed juice with an equal amount of distilled water, and injects this with aseptic precautions. He claims that the theory of the action of the diseased thyroid gland is incorrect and that myxœdema is dependent upon a perverted renal function.

Horsley (London), after reviewing the structure and functions of the thyroid and the results of its destruction and removal, concludes that it is an organ essentially connected with the metabolism of the blood and tissues, and that it secretes from the blood a colloidal substance which is carried by the lymphatics from the acini of the gland to the circulation. The hypertrophy of the remaining tissue, when a portion is removed, would tend to prove its indispensability; so too do the remarkable results of transplantation of thyroid tissue. Its importance in the economy appears to vary with the activity of the vital processes, being greater in early life and decreasing with advancing years, but its extirpation is always followed by a definite array of symptoms of profound character. Like all complex and far-reaching processes, this *cachexia thyroidectomica* is a compound of several factors, and will vary according to the predominance of one or the other; hence the symptoms may be divided into three stages: (1) neurotic; (2) myxœdematous; (3) cretinic. Death may occur in any stage, according to the virulence of the disease, but, if it run its course, the symptoms will invariably follow the order given.—*British Medical Journal*.

TREATMENT OF STRICTURES DUE TO RUPTURE OF THE DEEP URETHRA.—Guyon (Paris) has found that perineal strictures due to traumatic laceration of the urethra are often followed by the most serious consequences, even though the rupture be incomplete. This is because the development and contraction of the cicatricial tissue is so rapid that the muscular walls of the bladder do not have time to hypertrophy, dilatation of this viscus taking place instead, as well as of the ureters and pelves of the kidneys. As such strictures rapidly recur, even after the most thorough division, resection of the diseased area affords the only chance of permanent cure.—*Annales des Maladies des Organes Génito-Urinaires*.

Keyes (New York), in a case of traumatic contraction of the deep urethra, excised the stricture and practised urethroplasty with success. The patient (æt. 60) had fallen across a beam, rupturing the urethra twenty-eight years previously. Retention, infiltration, abscess and fistula followed, and were relieved by perineal section, but the stricture recontracted until only a fine filiform could be passed. After division, the dense fibrous stricture, one and a half inches long and extending from the bulb under the pubic symphysis, immediately sprang together. It was accordingly excised and the bleeding checked by pressure and hot compresses. After thorough disinfection, a piece of the inner layer of the prepuce (which was quite long) was removed and stitched in the gap in the roof of the urethra by catgut sutures applied laterally and anteriorly. The prostatic end could not be reached and sutured. The graft was pressed in place by a drain through the wound and a catheter through the urethra. These were removed on the eighth day, and the graft united, with the exception of a small portion anteriorly. Prompt healing followed, with marked improvement of the symptoms. A moderate linear obstruction was found at each extremity of the graft. At the end of a year the condition was the same, a twenty-one French sound being passed with ease once a month.—*Journal of Cutaneous and Genito-Urinary Diseases*.

A RARE CASE OF ASCITES.—Streeter (Chicago) records a unique case: A girl of seventeen was suddenly taken with severe pain in the lower abdomen which laid her up for a week, and was followed by the development of ascites. In three weeks she was tapped and twenty-four pounds of fluid drawn off; after a like interval an equal amount was removed. This had to be repeated more and more frequently until she was tapped every five days, or one hundred and thirty times in two years and a half, removing in all, three thousand one hundred and sixty pounds of fluid. The urine was normal. There were four liquid movements of the bowels daily, and she had no thirst, nor did she drink an excessive quantity of water. Section showed a fibroid that did not obstruct abdominal circulation, which was removed; no ovaries, no tubes, and a uterus that would weigh about two drachms. The girl had never menstruated, and the mammae were absent. Recovery was good. The girl was said to have grown three inches while in bed, and the dropsy did not recur. The tumor probably acted as an "irritant" in producing the dropsy.—*Medical Era*.

BOWEL OBSTRUCTION RELIEVED BY SHORT CIRCUIT.—Atkinson (Leeds), in a

case of bowel obstruction, found an extensive matting together of the coils of small intestine in the right iliac fossa, from ancient adhesive bands, which prevented any search for the cause. The colon being collapsed and empty, an anastomosis was made by means of Senn's bone-plates between it and the nearest distended loop of the ileum. Relief was immediate and recovery uninterrupted for three weeks, when the case was reported.—*London Lancet*. (It would be interesting to know the after-history of this case with a view to deciding whether enough intestine had been excluded to produce malnutrition.—Eds.)

CONGENITAL DISLOCATION OF THE HIP.—Lannelongue (Paris) succeeded in creating a new rim for the acetabulum by the irritative action of chloride of zinc, and thus preventing the slipping upward of the head of the femur in a case of congenital, unilateral luxation. The limb was extended and twenty drops of ten per cent. chloride of zinc solution injected in a semi-circle above the head of the femur along the surface of the ilium. There was no reaction, but in ten days a firm, almost bony projection could be felt along the line of injection. Two weeks later the same amount was again injected along the same semi-circle and above it. As a result there was found a large, hard, painless ridge above the head of the femur which held it in position, and enabled the child to walk well. Lannelongue considers this to be the result of an osteitis set up by the chloride of zinc, and thinks the result will be permanent. He had previously experimented on rabbits with like results. Chloride of zinc, too, he has found very useful in two cases of tubercular arthritis; in both there were sinuses and persistent suppuration, which healed, leaving satisfactory function.—*La Tribune Medicale*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

OPERATION FOR ECTOPIC GESTATION.—Dr. Lieth Napier, discussing ectopic gestation, said that it was worthy of note that more deaths were due to post-operation hæmorrhage than to sepsis. He advised that the sac should be fixed to the abdominal wall, drained, and if need be stuffed with antiseptic gauze, which would act not only as a drain but also maintain internal pressure and prevent hæmorrhage. In cases where septic peritonitis and a fæcal fistula existed, drainage was an absolute necessity. In cases with a fresh placenta, we must keep the dressings strictly aseptic; after twenty-four or forty-eight hours it might be possible to remove the drain and allow the opening to heal up. Doing a double operation, primary to save the fœtus, and secondary to remove the placenta if subsequent trouble arose, was doubtless the ideal.—*The British Gynæcological Journal*, 1892.

MATERNAL CONDITIONS IN SYPHILIS.—Dr. Thomas F. Nunn knows of no instance where, contrary to advice given by him, a syphilitic man has married, the wife has escaped contamination, even when no pregnancy has resulted from the marriage. Specific treatment during the course of pregnancy appears to have little effect and does not save the infant from congenital syphilis. But when pregnancy is terminated, treatment has a fair field. It must then be steadily put in force, and must be periodically repeated. It is the opinion of many that syphilis causes premature delivery rather than abortion. Dr. L. Napier said the influence of syphilis as a factor in the production of abortion before the sixth month had been vastly exaggerated. Not more than nine per cent. of such cases were due to syphilis.—*The British Gynæcological Journal*, 1892.

VAGINAL HYSTERECTOMY.—Dr. Bantock is of the opinion that the best method would, in the long run, be found to be that of separating the bladder from the uterus in front, opening into Douglas' pouch behind, applying ligatures on each side and dividing between them and the uterine body, and finally closing the peritoneal opening. He preferred suturing the peritonæum only, to the method adopted by Olshausen, who includes also the vaginal mucous membrane in his suture. By the former method, in which the raw surface is carefully excluded from the peritoneal cavity, any oozing escapes freely into the vagina.—*The British Gynæcological Journal*, 1892.

OPERATION FOR NEUROTIC CONDITIONS.—The consensus of opinion was against operating in simple neurotic conditions; for while in some patients operation seemed to do good, others became perfectly well without such procedure, and a third class seemed to obtain no relief but to be left worse than before.—Dr. Leith Napier in *The British Gynecological Journal*, 1892.

PELVIC PERITONITIS.—The recent publication on pelvic inflammation by Terillon corroborates what is now held as the foundation of our beliefs—viz.: salpingitis, oöcystitis, pelvic peritonitis; septicæmia, pelvic cellulitis.—*The British Gynecological Journal*, 1892.

ABDOMINAL DRAINAGE.—In placing the tube in position the following precautions must be observed. The surgeon must pass two fingers, with the palm or face towards the pubes, down to the very bottom of the cavity to be drained, and keep them there until the tube is placed, being sure no bowel is left under the tube; it should now be held in place while the remainder of the patient's toilet is made. If displaced, as much care as before must be taken to replace it. Great care and cleanliness should be practiced in the toilet of the tube. A long nozzle syringe should be used for the purpose; an addition of a short piece of rubber tubing should be used where the nozzle of the syringe does not extend to the bottom of the glass tube. The tube should be cleaned before closing the wound, so as to be sure there is no hæmorrhage, and again as soon as the sutures are placed and tied, a rubber dam should be placed over the tube to protect the dressings; this may be done by a mere nick in the rubber. A handful of absorbent cotton should be placed around and over the tube, and the four corners of the rubber pinned over all; another pin fastens the rubber to the bandage. The rubber should be from twelve to fourteen inches square, and over the entire dressing a wide and soft towel is placed and pinned to the bandage. When the drainage or hæmorrhage or both are profuse, the cotton should be changed and the tube cleaned every twenty minutes, and at least once an hour for the first six hours, and as the discharge lessens the time may be longer. The nurse should never leave the patient while the drainage-tube remains in the abdomen; this is a precaution not to be neglected. If the glass tube remains in place for thirty-six hours or longer, it must be followed by a small rubber tube, and the latter should be removed half an inch at a time at every dressing until the tube is out. Mischief has never resulted where the tube was cautiously managed and removed as directed. Previous to removal of the drainage-tube, the bowels should be prepared to continue the drain by purgation. The glass tube should be long enough to come out of the wound at least half an inch to make room for the dressing.—*Annals of Gynecology*.

PREVENTION OF FÆCAL FISTULA FOLLOWING LAPAROTOMY—A. P. Dudley. —Though some of the older operators prefer to work in the pelvis through the smallest possible opening, the experience of the writer teaches that the probabilities of injuring the intestinal coats are much increased thereby. Next to direct injury, the most frequent cause of fistula is the indiscreet or improper use of the drainage tube. A third danger is the use of catgut in intestinal surgery. In two cases occurring in the practice of the writer, one started in the sigmoid flexus twenty days after laparotomy was made; the other in the cæcum, two months after the operation. After locating the sinus and thoroughly washing it out with 1:1000 mercurial solution, a tampon of marine lint saturated with balsam of Peru was carried directly through into the bowel. This dressing should be repeated daily and the tent kept in the bowel until the opening has become quite small; then the bowel should be thoroughly cleansed with a cathartic and kept at rest until the opening in the bowel is closed. The sinus should be kept packed with marine lint until it is closed. The secret of success is the proper management of the bowel, to keep it well employed, free from gas, and, above all, well irrigated. In all cases of intestinal surgery abstain from using catgut, and employ in its stead fine silk that has been properly prepared. The continuous suture is safer than the interrupted.—*American Journal of Obstetrics*, February, 1892.

COCAINE INTOXICATION.—In three reported cases, the symptoms were briefly as follows: In the first case, the cocaine having been injected for curetting, in about half a minute the patient complained of chilliness of the whole body and great restlessness, and although she had just been catheterized, immediately voided a large quantity of urine. She could not stand and soon after was seized with convulsions; the whole body was flexed. The respiration became more frequent,

heart beat 150 though regular. The face was convulsed, the tongue immovable, sterno clido-mastoid tense and consciousness lost. On account of the convulsions chloroform was administered; soon afterward patient complained of burning and thirst in throat and again passed a large quantity of urine. After a pause of about five minutes the seizure began again and amyl-nitrate was given. Urine was passed at least every five minutes for half an hour. After a third attack, patient slept for an hour and the various symptoms decreased gradually. The next day the patient was well except for the polyuria which lasted about four weeks.

These symptoms were repeated in a more or less marked manner in all the other cases, especially the convulsive seizures over the whole body, the burning and thirst, and the irritation of the bladder, which was one of the longest lasting symptoms.—*Centralblatt für Gynäkologie*, No. 46.

THE INDUCTION OF PREMATURE LABOR.—In an exhaustive article on the provocation of premature labor, Dr. Oui draws the following conclusions from statistics in regards to the best means.

1. The sound of Krause should be rejected, except in case of absolute necessity. The labor which it induces progresses too slowly, and the infants succumb in much larger proportion than with any other instrument.

2. In a case where it becomes necessary to provoke labor in a primipara or in a pluripara with small os, the balloon of Taenier should be used, followed, when the cervical canal is sufficiently dilated, by the balloon of Champrier.

3. In the case where the permeability of the cervical canal is sufficient, the balloon of Champrier should be used at once.

4. This is the more clearly indicated by the need of haste in completing labor, and especially in premature rupture of the membranes.

5. The rupture of the membranes can be easily avoided with the Champrier balloon. Occasionally it penetrates the placenta but in that case it is only necessary to dilate the balloon, to arrest the hæmorrhage.

6. The balloon should not be completely filled in the beginning, for in that case it develops above the superior strait, and does not sufficiently excite uterine contraction and favors change of position.

7. These changes of presentation appear to be produced quite frequently with the balloon of Champrier, and it is necessary to watch carefully in order to correct quickly any vicious presentation which it may produce.—*Annales de Gynécologie et d'Obstétrique*.

DR. STRATZ, of Batavia had the opportunity to examine a thousand Java women, mostly prostitutes from 16 to 30 years of age. Only 162 were in good health. There were 605 case of retroflexion; 130 cases of ovarian tumors; myoma 90; uteri in a state of arrested development, 24; salpingitis or tumors of the tubes, 104; parametritis 25; prolapsus 22. The great number of retroflexions is noticeable and the author accounts for the fact on the ground that massage was used so commonly for many diseases and also from the fact that the means commonly used to prevent conception, is to produce retroflexion by extreme pressure on the uterus from the abdominal wall.—*Centralblatt für Gynäkologie*, No. 39.

THE RELATION OF RHEUMATISM TO THE NEUROSES.—Dr. Edward Blake, of London, sums up as follows:

1. It seems probable that those agencies which are prone to produce neuroses are also capable of causing arthropathies. Such agents as lead, sepsin, alcohol, arsenic, quinine, carbon disulphide, marsh miasm, traumatism, mental shock, senility and starvation which can induce rheumatism or gout may instead of arthritis induce a neural, a cerebral or a cutaneous change.

2. There are substantial grounds for suspecting the existence of an inhibitory centre for the uterus above the spinal cord. There are reasons for locating this centre near the vagal nucleus.

- (a.) The influence of this centre may be impaired by some of the agencies which causes arthropathy in man, setting up a corresponding change in women representing dysmenorrhœa.

- (b.) The inhibitory influence, instead of being merely impaired, may be completely suspended during pregnancy. Thus abortion may come to pass.

- (c.) The presence of such a centre with an inhibitory rather than a mere trophic function would explain why anæsthesia may not alone be unable to arrest the progress of labor but may actually facilitate expulsion.

OPERATIVE TREATMENT OF APPENDICITIS.—Operate not later than the third day of the disease if there has been no marked improvement, especially if the bowels have not moved—these are apt to be fatal cases. We should invariably operate as soon as the presence of pus is assured; when peritonitis is developing or spreading; when signs of sudden rupture of an abscess into the peritoneal cavity appear, and where septicæmia from septic absorption is taking place. In children, the operation must be performed earlier than in adults, as with them, the malady is more speedy in development, more fatal in tendency, and shows greater proclivity to involve the general peritoneum. Pain is not a reliable symptom (especially when opiates have been administered) from which to judge whether the patient is better or worse; much weight should be given to the strength, temperature, and condition of the bowels, stomach, and general abdomen.—T. S. K. Morton, M.D., in *The American Gynecological Journal*, February, 1892.

THE INCLINED PLANE IN THE TREATMENT OF DISEASES OF WOMEN.—Dr. Emmet has observed that there seemed to be scarcely any condition of disease in the female pelvis, which was not benefited to some extent by maintaining the recumbent position, with the foot of the bed elevated from twelve to eighteen inches. If elevated less than twelve inches, the intended effect of gravity on the pelvic organs and circulation would not be obtained. Patients are thus often enabled to get sleep who, without the elevation, lay awake all night. The writer is convinced that this is due to lessened pelvic circulation. He never tried it on patients who were fleshy or suffering from cardiac trouble. The position was of marked value in the treatment of enlarged and prolapsed ovaries in threatened attacks of pelvic peritonitis, in cases of pelvic inflammation where tamponing of the vagina so often proved of benefit, in tubal disease, and in irritation of the bladder, so often attending local peritonitis about the utero-sacral ligaments.—*The American Journal of Obstetrics*, March, 1892.

THE SURGICAL TREATMENT OF EXTRA-PERITONEAL EFFUSIONS.—Dr. Munde advocates chiefly aspiration, incision, and drainage through the vagina, whenever practicable, and an avoidance of opening the peritoneal cavity in all cases where the accumulated fluid can be evacuated without injury to the peritonæum. A more or less fluctuating doughy mass situated above the vaginal vault to one side or the other of the uterus, with the uterus movable from above downward, but restricted in its lateral movements, indicates an intra-peritoneal exudation. When a large, fluctuating, and doughy mass extends into the pelvic cavity below the level of the vaginal vault, and even of the cervix, and between the rectum and vagina, or between the bladder and the uterus, it must be extra-peritoneal.—*The American Journal of Obstetrics*, March, 1892.

DRAINAGE WITH GAUZE PACKING AS APPLIED TO THE UTERUS.—Cleanse the vulva, the vagina, and the cervical canal, as if it were your intention to take out the uterus; dilate the cervix so you may introduce the speculum; then irrigate the uterus with bichloride 1-2000. At the commencement of the anæsthetic, you place the gauze (the strip as prepared for the interior of the uterus, and a good piece as it comes from the can) in the 1-500 bichloride solution; squeeze the strip dry, and then by means of the tampon-screw, carry it section by section into the uterine cavity. The subsequent treatment consists of rest in bed for a week, the use of a saline cathartic the second day; hot fomentations over the supra-pubic region if there be disturbing pain. The gauze is left undisturbed in the uterus until the sixth day, when in case it has not been expelled by contractions, it is removed and a cleansing vaginal douche given.—W. M. Polk, M.D., in *The New York Journal of Gynecology and Obstetrics*, February, 1892.

ASEPSIS AND ANTISEPSIS.—According to Dr. A. G. Gerster, the epidermis and hair contain harmless and noxious germs, and are more or less coated by various oleaginous substances, which prevent the penetration of all watery solutions. This coating is best removed by an emollient potash soap, hot water, and a stiff brush made from the bristles of the hog. Hands are sterilized by trimming the nails and scrubbing with brush and soap in hot water. The hands are then immersed in strong alcohol, then in a $\frac{1}{1000}$ solution of corrosive sublimate.—*The Archives of Gynecology*, February, 1892.

HYDRASTIS CANADENSIS IN OBSTETRICS.—Bossi, of Genoa, finds that the fluid extract, administered in doses of 100 to 200 minims daily for several days, has no evil

effect on either mother or child. It is equally innocuous during delivery. It has a constant, curative and prophylactic and hemostatic action on the uterus during pregnancy. It is infinitely preferable to ergot, and much less dangerous when distributed to midwives for use in hospital and in private. Bossi gives from 100 to 150 minims daily, in three doses, during hæmorrhage in pregnancy or labor. He also administers it as an immediate curative agent in flooding during labor, in three or four doses amounting to 200 minims.—*The Archives of Gynecology*, February, 1892.

INCLINED DECUBITUS.—Thomas Emmet, M.D., relates the following case: The patient had suffered from repeated attacks of peritonitis, there was a slight discharge of pus from the vagina, and frequent rigors, with a rise of temperature every afternoon. The right tube was distended with pus to about the size of a wrist and lying behind the uterus, which was crowded well forward and firmly fixed against the bladder. Her general and local condition contraindicating immediate operation, she was put to bed, the foot of which was elevated some eighteen inches, and almost immediately a free and continuous drainage of pus was established through the uterine canal. In less than a week the rise of temperature in the afternoon ceased, and the improvement was so great that she was allowed to get up for local treatment. Twice this was attempted, and the escape of pus ceased with increase of pain, return of rigors, and increase of temperature in the afternoon. After remaining on the inclined plane for five weeks, it was found, upon examination, that the right tube had become reduced in size to about that of the little finger and had returned to its normal position. The uterus was smaller and decidedly more movable. The patient now returned to her home where the use of the inclined plane was continued, and her steady improvement warrants the opinion that a cure will be accomplished.—*New York Journal of Gynecology and Obstetrics*, February, 1892.

ELECTRICITY APPLIED TO THE UTERUS.—It is a grievous mistake to apply the galvanic current directly to the uterus in cases of amenorrhœa dependent upon anemia. In many of those neurasthenic, weak and hysterical conditions, following and dependent upon the process of child-bearing, and especially if with some form of deranged menstruation, purely the external application of electricity is a remedy of the utmost value. If these menstrual disturbances are dependent upon demonstrable local disease rather than upon constitutional disturbance, local methods are imperatively demanded. In the treatment of cases of subinvolution, induced currents of quantity are far superior to those of tension. The current of great quantity but low tension is entirely inefficacious, if used by the uni-polar method, but acts with astonishing vigor if both poles are applied internally. The current of less quantity but greater tension acts promptly, even when one pole is placed externally. Applied by the bi-polar method, it acts with such vigor as to render the utmost caution necessary.—A. D. Rockwell, M.D., in the *Homœopathic Journal of Obstetrics*, March, 1892.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

THE TREATMENT OF TRICHIASIS AND ENTROPION.—W. A. McKeown, of Belfast, gives the following objections to the operations in vogue for trichiasis and entropion. First, unnecessary destruction of tissues; secondly, complexity and difficulty of execution; and thirdly, uncertainty. I will not discuss, or even name, these different operations, but proceed to describe a method which I have practiced extensively, and which I think will supplant all other methods. The operation is as follows:

First stage: If the upper lid is to be operated on, introduce the smooth handle of a dessert-spoon under the lid, to protect the eyeball and support the lid; let the assistant hold it whilst the surgeon steadies the lid on the handle with the left hand, and with the right hand introduces a Graefe's cataract knife at the margin of the lid between the eyelashes and the Meibomian glands, either close to the punctum or at the outer canthus; then, push the knife beneath the skin about as far as the orbital margin, and by to-and-fro motion cut along the whole of the lid-mar-

gin until the lid is split into two layers, the outer layer containing the skin and eyelashes, the inner layer the cartilage, Meibomian glands, etc. If the skin and hairs can be moved freely upwards, the section has been properly made; if not, blunt-pointed scissors should be passed into the section and any tissue preventing free motion cut.

Second stage: The skin and eyelashes are glided upwards, so as to expose about two lines of the cartilage, and are to be secured in their new position as follows: A curved needle with a strong silk iodoformed thread is to be passed through the skin at the middle of the lid, about two lines from the eyelashes, then through the cartilage, emerging on to the conjunctival surface about four lines from the margin, and then the needle is to be passed back again through the cartilage and skin, coming out a line or so from the original point of entry on the same horizontal line. A thread is then passed, in the same way, near the outer and inner canthus, respectively. The skin layer and the cartilaginous layer of the lid are now secured by three loops of thread in such a way that the lashes must be displaced upwards far from the eye. Each thread is tied, with moderate tightness, over a tiny roll of lint or cotton-wool. Adhesion of the two layers in the new position quickly takes place.

Third stage (grafting): A graft is taken from the back of the ear by passing a Graefe's knife under the skin for about an inch, then cutting out on one side, and separating the attached side by fine scissors. It is then placed on the back of the left hand, and all subcutaneous tissue removed by the scissors, and blood removed with lint soaked in warm boracic acid lotion, and the graft applied immediately to the exposed surface of the tarsal cartilage, previously cleansed of all clots with the boracic acid lotion. Perchloride of mercury is not desirable in grafting operations because of its coagulating power. The graft is adjusted carefully with the probe, and the dressing not applied until it is pretty well adherent.

Fourth stage (the dressing): Apply a little strip of lint, saturated with warm iodoform and vaseline ointment, over the graft, and on the top of that a piece of lint to cover the whole eyelid, similarly saturated, then dry lint and bandage. Both eyes are bandaged, the patient is put to bed and not disturbed for four days. At the lapse of that time the stitches are removed, but the eye operated on is bandaged for three or four days more.

The features of this operation are: 1. No skin or other tissue is destroyed or removed, save in thickening or distortion of the cartilage. 2. Expedition in performance. 3. Certainty of immediate result, and no liability to relapse. 4. Its applicability to all sorts of trichiasis and organic entropion.

"Spastic entropion" of the lower lid may be sufficiently relieved without any operation at all. All that is necessary is, to put a little pressure on the lower lid, and that may be conveniently done by a spectacle-frame of such a form as to press on the lower lid, or, if that cannot be found, by putting a ledge on the lower edge of a frame. Patients prefer this simple and effectual method to any operation.—*The Lancet*, April 2, 1892.

A CASE OF NASAL REFLEX.—The patient suffered very much, was relieved by simple treatment and was kept under observation a sufficient length of time to confirm the diagnosis.

A young lady, an art student, aged 18, complained that she could not use her eyes for near work without great fatigue. After reading for a short time she had considerable headache. In consequence she was compelled to stop her studies. Tonics and rest of the eyes gave her no relief. The condition grew steadily worse. Several weeks later she complained of seeing double. Insufficiency of the interni was found; instillations of atropine showed the eyes to be nearly normal, requiring no glasses.

One month later the eyes were no better. Headaches still severe. After the application of cocaine to a sharp projecting point on the left side of the septum, the eyes felt better and the patient could read with more comfort. Ten minutes later, when the effects of the cocaine had passed off, the tired feeling in the eyes returned; cocaine was applied to other portions of the nose without relief. It seemed that this sharp spur was causing a reflex irritation in the eyes. Under cocaine this sharp point was removed with the nasal saw. Immediately the patient stated that the eyes felt very much better. She could now read diamond print with perfect comfort.

Four months later, no more trouble with her eyes or head, and had resumed her

studies. It is interesting to note that the insufficiency of the interni was still present, and that she had had several colds in her nose without affecting her eyes injuriously.

After four months again the patient reported that she had had no trouble with her eyes until about three weeks ago. Last summer her nose was injured. A physician inserted at this time a probe into the left nostril to straighten the nose. The doctor was not sure that the nose was broken. Now she suffers so much with pain in her eyes that she is unable to work. The insufficiency of the interni is still present. An examination of the left nostril shows some projecting tissue on the site of the old operation. Under cocaine this was removed. The eyes felt relieved immediately. One month later the patient reported that she had returned to work and that her eyes still felt relieved.—W. H. Bates, M.D., in the *Medical Record*, February 17, 1892.

RELIEF OF EYE PAIN BY THE HOT-BOX.—Dr. Chisolm, writing in the *Annals of Ophthalmology and Otology* for January, 1892, says that two years since, when visited by a medical friend from Japan, his attention was called to a small flat hot-box which was said to be in universal use in that country as a pain-killer. The box was a little smaller than the hand in length, breadth, and thickness. It was slightly curved in shape as is the hand when it begins to close, so that the concavity can apply well to the rotund parts of the body. The box was made of very thin sheet copper or tin, perforated with a few small holes to allow of the admission of air. Over the top was a sliding lid fitting accurately into the groove. The metal box was covered with colored muslin. The heating power was a cartridge, resembling a large Chinese shooting cracker. It was made of powdered charcoal firing wrapped in paper. It was about four inches long, as large in circumference as the index-finger, and would burn under slow combustion for nearly three hours. One of these charcoal packages, when lighted and closed up in the box, would burn slowly owing to the small amount of air admitted through the perforations in the metal, and would keep up a temperature about 120° F. The metal was so thin that the box had but little weight.

These pain-relieving boxes are to be found in every home in Japan, and are in universal use for the relief of pain wherever located. Hot cloths are so soothing in the relief of eye-pains that Dr. Chisolm determined to experiment with this hot-box from Japan, and he says that it is now one of his most trusted agents for the relief of pain in many eye diseases, such as iritis, scleritis, corneal ulcers, and glaucoma. His method of application is as follows: After the fuse has been lighted and the box has become warm, it is enveloped in the folds of a handkerchief and secured to the head by the ends of the handkerchief. A little loose cotton applied over the closed eye fills up the socket and allows the heat to be transmitted directly to the painful organ. The handkerchief protects the face from the edges of the hot-box. Once applied it needs no renewal for two or three hours. In many cases the relief of pain, the author says, is magical. In old persons he has avoided the necessity of removing painful eyes lost by glaucoma by the use of this hot-box; in some cases in which, previous to its application, the disease had resisted both iridectomy and medication, local and general. The Japanese hot-boxes and cartridges can be found at all Japanese stores, are also kept by many druggists. Dr. Chisolm says that they commend themselves for their convenience, simplicity, economy, cleanliness, and efficiency as an application for the relief of pain, and finds in them the most valuable method of applying dry heat as a remedial agent.

EFFECT OF DISEASE ON THE EYELASHES.—"A Subscriber" to the *Lancet* reports a case in which the eyelashes of the inner half of the upper eyelid have become quite white. The lady having black hair, the effect is quite conspicuous. She has not suffered from neuralgia, nor is there any assignable cause. The lashes have been painted with nitrate of silver, but without effect.

POISONING BY HOMATROPINE.—In the *Medical News* (New York) Dr. Purley related the particulars of a case in which symptoms of poisoning by atropine developed after the repeated instillation of drops of a 2 per cent. solution of homatropine into the eyes. The patient was a child of seven, who was the subject of hypermetropia. To procure relaxation of accommodation she was ordered to have homatropine solution dropped into her eyes every fifteen minutes for an hour before returning for examination. She came at the appointed time, and while at Dr. Purley's house nothing unusual was observed. The pupils, as was to be ex-

pected, were well dilated. On the way home, however, she became restless and excited, the face was flushed, and her mental condition was peculiar. Her ideas, which were very rapidly expressed, became very incoherent and extravagant, and she saw imaginary objects. Her gait became staggering, hallucinations were very marked and accompanied by mild delirium. She was treated by the family doctor, and the following morning was very much better, but it was several days before she had entirely recovered. The case is certainly curious, for Dr. Purley calculates that only about two-fifteenths of a grain could have been instilled, and, considering how small a proportion of this was likely to be absorbed, it was scarcely to be expected that toxic symptoms would have been produced.

NYSTAGMUS IN AFFECTIONS OF THE EAR.—On the basis of four observations, Dr. Cohn concludes: 1. Nystagmus sometimes occurs during suppurative otitis media, with perforation of the membrana tympani. 2. The attack is generally of short duration and associated with severe vertigo. 3. The attacks are rarely spontaneous; they are usually due to mechanical excitation of the deep portions of the ear; injections of cold water are especially apt to be the cause. 4. Nystagmus is always bilateral, and, as a rule, horizontal, but more rarely rotary. Here is a point of etiology worthy the attention of ophthalmologists.—*Revue de Laryngologie*.

RESORCIN IN LARYNGEAL PHTHISIS.—Dr. Tymowsky considers resorcin the most convenient of all local applications, because it gives no pain, and need only be applied once a day. The solution must be of the strength of 100 per cent. in cases of unhealthy-looking ulcers, which are undoubtedly of tuberculous character. At the same time, inhalations of from two to five per cent. solution of resorcin may be substituted for those of cocaine.

PRESCRIBING OPTICIANS.—According to a decision recently given by a judicial authority at Havre, an optician who gives a patient advice as to the condition of his eyes, and prescribes glasses to remedy defective vision, is guilty (according to French law) of the illegal practice of medicine, just as if he had ordered remedies or given medical advice without possessing a diploma recognized by the law.—*British Medical Journal*.

PRELIMINARY TREATMENT, CATARACT OPERATIONS.—The patient should be dieted for a number of days prior to operating. Meats should be lessened, and vegetables increased. One week previous to the operation, the eye should be bathed twice daily with hot water and followed with lotion boracis, and the night before the operation an ointment of hydrargyrum applied over the brow of the eye selected. The blood must be made strongly alkaline, and defibrinated by the internal use of hydrarg. bichloride and potassium iodide pushed just beyond their tonic effects. Just before operating, the eyeball should be thoroughly cleansed. This is the plan, in brief, adopted by Dr. L. W. Fox, of Philadelphia, as given in the *Annals of Ophthalmology*, April, 1892.

A NEW METHOD FOR REDUCING INTRAOCULAR PRESSURE.—Tailor describes a new method devised by de Vincentiis for reducing the intraocular pressure, which consists in making an extensive incision of the iris-angle at the lig. pectinatum with a sickle shaped needle. The instrument, which must be so constructed that, after its introduction and during the incision, no aqueous can escape, is passed in through the sclera one and one-half mm. from the corneal margin, and pushed across to the other side parallel to the iris; the incision is made by drawing it back. Experiments made upon twelve dogs showed beyond a doubt that this little operative procedure reduced the tension, which did not return to the normal until after two to five weeks. He then tried it in eight cases of absolute glaucoma, with marked increase of tension. He claims to have obtained a remarkable result; the tension was reduced in every case, in some below the normal; the symptoms of irritation disappeared. The patients were kept under observation for months; only one had a relapse.—*Archives of Ophthalmology*, April, 1892.

A NEW FAD.—It is said that a Vienna ophthalmologist has introduced a new operation, over which some of the European eye-specialists are running wild. The operation consists in the removal of the crystalline lens for the cure of myopia. Valude reports one operation of this nature performed upon a child only six years old.—*The Times and Register*.

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

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TREATMENT OF ENDOCARDITIS.—Dr. P. Jousset, of Paris, France, outlines the treatment of endocarditis. This disease is found as a complication of acute articular rheumatism; it may also be associated with a continuous or eruptive fever and especially in scarlatina. It is frequently seen in the purulent diathesis. Finally it may arise from simple extension of inflammation in pneumonia, pleuritis or even an intense bronchitis. The writer first gives the treatment of the common form and then that of the malignant or infectious variety.

Treatment of the Common Form.—The principal remedies are: aconite, cactus, spigelia, colchicum, lachesis, belladonna, cannabis, arsenicum, phosphorus and tabacum are also indicated.

Aconite.—Richard Hughes and the majority of writers place aconite at the head of the list in treatment of acute endocarditis. It is the remedy for the beginning. It is indicated by an intense fever, a hard and rapid pulse, energetic action of the heart with distressing pain, sensation of a violent blow in the precordial region or epigastrium, heat and redness of the face, thirst, tendency to syncope, short respiration, dark colored urine; an intermittent pulse does not contraindicate. Dose 20 to 30 drops of the mother tincture in 200 grammes ($7\bar{3}$) of water; a spoonful every two hours.

Cactus.—Cactus is an analogue of aconite. It is indicated by increased heart's action, precordial anguish, which is painful even to suffocation, sensation of a hand of iron compressing the heart, lipothymia, disappearance of the pulse, irregular pulse and slight symptoms of angina pectoris. This drug, introduced into therapeutics by Rubini, is recommended by Richard Hughes and O'Brien. The lower dilutions and the tincture are to be preferred in very severe cases. The writer administers three drops of the mother tincture in 200 grammes, $7\bar{3}$, of water; a teaspoonful every two hours. [I have taken a pint of the homœopathic tincture of cactus during the course of an afternoon, and, beyond the alcoholic exhilaration, perceived no results. French (allopathic) writers give as high as 100 to 200 drops per diem —Eds.]

Spigelia.—Somewhat analogous to the two preceding. It is indicated when the disease is well under way and no longer incipient. Agonizing pain in the precordium, which radiates along the phrenic nerves and those of the brachial plexus; here the similarity to angina pectoris is well marked. The irregular pulse, its intermittence, threatening syncope, the considerable dyspnoea complete the clinical picture. If the accelerated pulse is replaced by a slowness, this remedy is also certainly indicated. Dose, the same as of cactus.

Colchicum.—The pathogenesis of colchicum is poor in heart symptoms. Roth enumerates but two: a strong heart's action and a tearing pain in the cardiac region. The pulse is small, accelerated, filiform and trembling; it may also be slow and intermittent. Petros pointed out colchicum as a remedy in acute endocarditis, and as specially indicated when it complicates acute articular rheumatism and where aconite is found insufficient. The tincture of the seed is more efficacious than that of the root. The writer usually prescribes 10 drops of the mother tincture in 200 grammes, $7\bar{3}$, of water; a spoonful every two hours.

Arsenic.—Arsenic is more indicated in acute than chronic endocarditis; its place is where the action of aconite and cactus terminate, and when the dyspnoea, weak and irregular pulse, with considerable diminution of the arterial tension indicate a state of great gravity. Anxiety with agitation and nocturnal aggravation are confirmatory symptoms of arsenic. A commencing anasarca, congestion of the liver,

and a certain degree of albuminuria complete the picture of symptoms. The third trituration is the author's favorite. Tabacum, phosphorus, belladonna and cannabis present symptoms too little characteristic, both in materia medica and from clinical use, to enable one to outline their indications.

Treatment of the Malignant Form.—This variety has also been called the ulcerous or infectious form, according to the dominant theory. This form is extremely grave. It presents two varieties—a grave form, with intermittent attacks of great severity, and a typhoid variety with a continuous course.

Malignant endocarditis nearly always ends in death, whatever treatment be employed. The homœopathic school is but badly armed against this disease, simply because practice has not confirmed the remedies indicated by their pathogeneses. Aconite and the sulphate of quinine are indicated in the intermittent form; arsenicum corresponds to the choleraic variety, and the snake-poisons are indicated in both forms.

Aconite and the Sulphate of Quinine.—This combination fits the purulent diathesis. Aconite corresponds to the elevated febrile movement, with anxiety and great agitation; the sulphate of quinine to the intermittence, with the malignant symptoms, the perniciousness of the disease. Among the heart symptoms produced by toxic doses of quinine, there is a very short period, at the first, when the pulse is accelerated, with increased heat; there is also weakness and slowness of the pulse, with lowering of temperature; in a more advanced stage, there is a very feeble and irregular pulse, with an associated lipothymic state, with considerable chilliness, cold sweat, lividity of the face and extremities, absolute loss of muscular power, and finally complete collapse, absence of the pulse, coldness, and syncope. This complex of symptoms reminds one of digitalis, and confirms the indication of quinine in malignant endocarditis.

Snake-Poisons.—The snake-poisons produce an extremely grave state, which may be compared with that of pernicious algid fever and cholera. The heart's action is increased; the pressure in the arteries falls from the very beginning; the increases to fall again in frequency; the patient's skin becomes covered with a cold, clammy sweat; his urine is suppressed; involuntary passage of the stools, and with violent colic, vomiting; a lipothymic state sets in, and death takes place from cessation of the heart's action.

Arsenic.—The cases of poisoning by arsenic present, as is known, a choleraic complex which exactly corresponds to the algid stage of cholera; indeed, the resemblance is so striking, that the two states are easily confounded. Again, the action of arsenic upon the heart has been noticed by all observers. It corresponds to the symptoms of collapse and malignity, and hence it is indicated in the malignant form of endocarditis.

Doses and Modes of Administration.—Aconite should be prescribed in the mother tincture—20, 30, and even 40 drops, in twenty-four hours. The sulphate of quinine should be given during the period of febrile decline, when the attacks are well marked, and in doses of one grain to one and a half grain, in three doses, of one hour apart. Arsenic is administered in the first few triturations, and the snake-poison from the 6th to the 3d dilutions; the dose should be repeated every hour. The writer has prescribed lachesis most frequently among the snake-poisons.—*L'Art Médical*, January, 1892.

TREATMENT OF SCIATICA.—Dr. E. Weber, of Cologne, Germany, in a paper read before the German Central Homœopathic Union, considered the treatment of Sciatica. He has found colocynthis, rhus, and pulsatilla to be the principal remedies.

Colocynthis.—This remedy has tearing and lightning-like pains, which follow the course of the sciatic nerve down to the foot. They may be so violent as to cause the patient to groan and cry out, and even to produce fainting. It corresponds to the worst cases. The hip-joint seems to be fixed to the pelvis and sacrum by iron bands, as it were. The muscles are spasmodically and fearfully tense and fixed. All motion is difficult, on account of paralytic symptoms, and extremely painful. After the attack has passed off there remains a numb sensation, and after the disease has become chronic, emaciation of the corresponding extremity sets in. Motion and cold aggravate, rest and warmth ameliorate. The case is most characteristically pronounced by these features.

Rhus.—In this form the disease originates in the ligaments and muscles, and expresses itself as a feeling of having been wrenched, stiffness of the joints—the limb

feeling as if made of wood—a sensation of pressure, heaviness, fatigue, paralysis, and a sensation as if the limb had gone to sleep. Therefore, *rhûs* is indicated in rheumatic sciatica as well as in the pains in the joints after active, and especially, passive overstretching of the articular ligaments, as well as after severe exertions. The accumulated and stagnant metabolic products of the muscular fibrillæ form a painful and paralyzing substance which prevents the contraction of the muscles, so that a careful and continuous movement of the limb will restore the current in the lymphatic and relieve. The same must hold good with the ligaments, for they are painful when first beginning to move, and only functionate well after they have been used for a time. The external application of warmth also ameliorates by stimulating the depressed cutaneous activity.

Pulsatilla—This remedy, which has such an action upon the blood, will relieve that form of ischialgia which is due to stagnation of the blood-current which slowly courses upwards, which, thick, dark, and stagnant, fills the capillaries and veins to overflowing, and gives rise to a form which may be called venous sciatica. Therefore, the symptoms never reach any very great intensity, which has led to its being used in the milder forms of the disease. There is a sense of fatigue, heaviness, a sensation as if the leg had been bruised, with a drawing pain which makes the patient restless. Everything that increases the venous stagnation and the consequent swelling, aggravates. Hence rest, pendant position of the leg, and standing aggravates the patient's condition. Exercise favors the upward movement of the blood-stream, by the alternating contractions of the muscles, relieves the pressure upon the nerve-fibres, and hence gives relief. The external application of cold, also, has a similar action, for, by its constrictive action upon the cutaneous blood-vessels, it forces the blood into the deeper and larger blood-vessels, where the current moves more rapidly, thus relieving the cutaneous vessels, where the *vis a tergo* is small. Warmth, either of the room or bed, have the opposite action and therefore aggravate. The changing of the pains from place to place is due to stasis of the venous blood in various parts of the extremity.

These three remedies represent three types of sciatica: *Colocynthus*, that variety due to nerve-changes; *rhûs*, that depending on muscular and ligamentary involvement; and finally, *pulsatilla*, sciatica due to venous stasis. The writer divides the remedies of sciatica into three classes according to this pathogenic basis.

The *colocynthus* variety includes *arsenic*, *chamomilla*, *gelsemium*, *gnaphalium*, etc.

The *rhûs* variety contains those similar to it in action, as *bryonia*, *arnica*, *nuxvomica*, etc.

The *pulsatilla* type represents such as *sepia*, *belladonna*, *ferrum*, *sulphur*, *graphites*, *lycopodium*, *mercury*, etc. All these remedies cannot be regarded as local specifics, like the three preceding ones. They rather are to be used and indicated from the peculiar general symptoms, which are independent of all local phenomena in the sciatic nerve.

Arsenic will be found indicated more by its characteristic midnight aggravation, the associated anxiousness, the striking sinking of strength when the pain comes on, as well as the sensation of a fiery stream passing through the nerve. (One prominent English authority of the old-school, Dr. Fagge, regards *arsenic* as the most useful remedy in sciatica.—*Medizinische Neuigkeiten*, May, 1892.—Eds.)

Arnica is to be preferred to *rhûs* when the disease is due to crushing, tearing, with effusion of blood in the region of the sciatic nerve, together with the characteristic symptoms of *arnica* of restlessness, desire to move about, and over-sensibility.

Sepia is valuable where the slowness in the blood-current is due to plethora of the portal system.

Nuxvomica presents, together with its sciatic symptoms, those of the spine and abdomen.

Lycopodium is indicated, according to Dr. Hirschel, in sciatica, with tearing, drawing and jerking pains, tonic muscular contraction, which is apparently of central origin and is succeeded by rigidity, semi-paralysis, emaciation, etc. Iodide of potash is indicated as an antidote in mercurial sciatica and mercury itself in chronic cases. Dietterich, *Mercurialkrankheiten*, gives the following picture of mercurial neuralgia: The patient experiences a drawing and tearing pain along the course of a motor nerve. This pain may be fixed at any especial place, but it more frequently runs from place to place along the course of the nerve. If the disease has persisted for months, the pain not rarely jumps from the original place to another, especially

when the barometer is undergoing great changes. The pain presents distinct intermissions, which, however, are not typical and have no special type. If it has been absent for any length of time, only a slight draft, an over-exertion, or over-heating are necessary to have it set in again. Such patients do not bear dampness at all; dry heat and dry cold affect them least. Their functions are so changed that when they are exposed to the greatest heat they are at their best. When, on hot days, other persons seek the coolest spot, they find a real pleasure in exposure to the hottest rays of the sun.

When the sciatica is dependent on vertebral disease, then such remedies as cal., natr. mur., phos., silica, sulphur and allied constitutional remedies are indicated.—*Zeitschrift des Berliner Vereines Homöopathischer Aerzte*, Bd. x., Hfte. V. and VI.

THE THERAPEUTIC RANGE OF ASAFETIDA.—Dr. Puhlmann, in an address made before the Leipsic Homœopathic Union, after a preliminary review of the uses of the drug in the culinary art and its allopathic application, considers the homœopathic range of the drug. One of the most important uses of the drug is in osseous tumors and suppurative processes in osseous tissue which are of syphilitic origin. Dr. Franz cites a case where, together with a mercurial dyscrasia, there was an ulcer on the anterior surface of the tibia, which had become gangrenous and secreted a badly-smelling pus, and at the slightest contact was extremely painful. Besides that the entire leg was covered with small, flat, reddish, easily bleeding and very painful ulcers, while the ankle was œdematous. Asafetida 3x, given internally, produced an amelioration of the painfulness. The drug also relieves those cases of painful varicose ulcers which are so painful that no bandage can be borne on the leg. It is also useful in caries of the bone when the principal ulcer is surrounded by numerous smaller and painful ones. Asafetida is intercurrent and prepares the organism for the action of the principal remedy. It is rarely a remedy of service in the treatment of constitutional diseases, and here it resembles its analogues, moschus, castoreum, camphora, etc. It is a palliative which will be found useful in the treatment of acute and chronic diseases as an intercurrent remedy. Like camphora, etc., it can not be used with success in the high dilutions. Asafetida will be found useful in flatulent colic, with drum-like distention of the abdomen, as in hysteria; here the drug is to be preferred to *carbo vegetabilis*. In neurotic patients one often sees cases of articular pain which are regarded as articular neuroses. It appears especially on the flexor side of the joint and is ameliorated by pressure. Exercise or rest have no influence; no swelling can be discovered and the urine is normal. In this auricular neurosis, as well as in the innumerable forms of hysteria, asafetida is a serviceable remedy, and it should be thought of when no other symptoms are to be found. In syphilitic iritis it is indicated when pressure on the eye-ball ameliorates the pain; if it is aggravated, then aurum is indicated.—*Leipziger Populäre Zeitschrift f. Homœopathie*, Nos. 3 and 4, 1892.

THERAPEUTICS OF CARCINOMA.—Dr. A. C. Cowperthwaite, in a paper bearing this title, offers the following: *Arsenicum iod.* has been extensively used and is said to be especially useful in epithelioma and in cases originating from eczema.

Carbo animalis is most useful in scirrhus; caehexia well marked; tumor uneven, nodulated; skin loose, dirty, red-bluish spots; burning pain; pain drawing toward axilla.

Conium is the chief remedy in scirrhus; nodules and indurations in the mammary gland, with burning or stitching pains; needle-like stitches, usually worse at night; breast abnormally tender.

Cundurango. According to Lilienthal, this remedy is only efficacious in open cancers and cancerous ulcers, where it effectually moderates the severity of the pains. It does not act on scirrhus and indurated spots.

Kreasotum is often a valuable remedy, especially in mammary cancer; dwindling away of the mamma, with small, hard, painful lumps in them; pungent, bloody, ichorous discharge; rapid emaciation, weakness and prostration.

Phosphorus. Hard nodules, bluish color; sharp, lancinating pains; ulceration deep, with indurated edges; fistulous openings, with burning, stinging pains and watery, offensive discharges; bleeds easily; fungus hæmatodes.

Hydrastis may also prove a curative remedy, and the following may also be consulted: *Aurum met., calc. carb., graph., iodium, lach., merc., nitric acid, sulph., silica, sepiä and thuya.*—*Transactions of the Homœopathic Medical Society of Colorado*, 1891.

A PROVING OF QUININE.—Ten minutes after taking a small dose of quinine a woman had a severe attack of vomiting; there was a rigor and rise of temperature; the skin was covered with scarlatinoid eruption; the throat was very red and swelling painful; some of the joints were painful to the touch as in scarlatinoid rheumatism. In a few hours all the symptoms disappeared.—*Homœopathic World*, March, 1892.

PROVING OF KALI CHLOR.—Two cases of poisoning by chlorate of potassium, are recorded in the *British Medical Journal*, supplement, December 13, 1891. A young man, æt. 18, swallowed by mistake, a gargle containing 460 grains of potassium chlorate in hot water. The symptoms were these: Very shortly faint and extremely thirsty; two hours drank some beer, which produced violent vomiting, frequently repeated during the night; great pains in the hypochondria; next morning on admission to the hospital, he complained of headache, faintness, loss of appetite and constipation. Skin anæmic; ears, lips, and extremities cyanotic; rigors; slight jaundice; systolic murmurs in all cardiac areas, but pulse good and regular; great epigastric pains on pressure; liver slightly enlarged; great pain on pressure over the kidneys, urine scanty, highly albuminous, containing altered blood corpuscles; blood from fingers contained clumps and imperfect rouleaux; death took place in six days without convulsions or uræmic symptoms; the urine was suppressed all the time; vomiting and severe abdominal pain continued. Post-mortem; yellowish or red exudation into pleural and pericardial cavities; alimentary mucous membrane all inflamed and eroded in parts; kidneys much enlarged, œdematous, capsule adherent, liver and spleen enlarged.

An adult man was taking seven-grain doses. After taking twenty-four doses extending over eight days, he had the following symptoms: Faintness and constant thirst; urine which had been dark-colored lost this appearance; it was natural in color, and contained hyaline casts; numerous large ecchymoses and petechiæ on the legs, some œdema; albuminuria and thirst persisted. Appetite bad, ate little all the time he was taking the chlorate.—*Homœopathic World*, March, 1892.

IODIDE OF LIME IN CROUP.—Dr. A. G. Beebe looks upon the iodide of lime as almost a specific in the treatment of croup, whether membranous or otherwise. He uses the iodide of lime manufactured by Billings, Clapp & Co. He mixes the drug with sugar of milk in the proportion of the 1x, but does not triturate it, as he does not care to expose it to the air and light to that extent. This powder should be kept tightly corked in the dark. A powder of from three to five grains (according to age) should be given to the child every hour, half hour, or quarter of an hour, according to the urgency of the symptoms, until the cough becomes moist, and remains so during the night.—*Medical Era*, March, 1892.

A PROVING OF SALICYLATE OF SODA.—A German suffering from subacute rheumatism took two drachms of salicylate of soda inside of four hours. As a result he became rapidly hallucinated, manifesting delusions of persecution. A band of Odd Fellows had conspired to kill him. To avoid their persecutions, he attempted to escape by the window, and was only restrained by force from committing various acts of violence. During the evening of this day he became so unmanageable that his friends, unable to control him, sought aid from the police, the outcome of this being that the patient was incarcerated in a cell for the night. During the next four days the patient manifested all the phenomena of delirium tremens. Visual and auditory hallucinations possessed him. He refused all food, giving as a reason that it was useless for him to eat, as he was condemned to be hung. He gazed in a mirror, and immediately broke it by striking with his fist the demoniacal image his own reflection suggested. His attention was incessantly concentrated upon freeing himself from the restraints which had been imposed on him. When spoken to he responded pleasantly. He was neither coarse in speech nor action; his violence arose solely from his desire to elude his persecutors. His pulse was 130. His respiration was not visibly depressed. At the end of the fifth day his hallucinations gradually ceased, and the patient recovered his usual health.—*New Remedies*, March, 1892.

NICOTINE POISONING.—Dr. G. P. Sword, of Worcester, Mass., reports the case of a man, aged 58, a buyer and seller of tobacco. His illness began while walking in the street. Could not describe his feelings, but in a few minutes everything began to whirl, and if he had not succeeded in getting hold of a post, would have fallen.

This lasted from fifteen to twenty minutes before the dizziness passed off. When it did it left him in a weak condition. He said his heart felt as if it had stopped beating, and he was cold. In a few days, another of these violent turns made its appearance. This was followed by more pronounced weakness than the first. By this time, the patient was unable to walk more than a short distance; said his legs would not go, they seemed to give out. Could not go up stairs without sitting down on account of his heart pounding so. Said it felt to him as if it was trying to pump itself out. Could not or did not dare to eat much, because the food seemed to lie in the stomach undigested. He then began not to sleep. When he would lie down his heart would beat so hard he had to sit up. He then began to be nervous; could not bear to see anybody. Did not care to talk to any one; wanted to be left alone. He was an habitual user of tobacco; when not smoking he was chewing. His pulse was feeble, irregular and intermittent. Distressing palpitations. Peculiar twitching of the orbicular muscle of the eye; tremor of the muscles of both upper and lower extremities; marked contraction of the pupils; congested condition of the mouth and fauces; increased amount of saliva; respirations short, quick and anxious in character; peculiar dark condition of the skin, and the hands presented a cold clammy feeling to the touch. The administration of ignatia and the abandonment of tobacco entirely were followed by a perfect cure.—*N. E. Medical Gazette*, January, 1892.

MAGNESIA PHOS.—Dr. A. L. Monroe says that magnesia phos. is doing noble work for him in the treatment of the agonizing pains that accompany muscular spasm, especially of the involuntary spasm. It has been especially valuable in the treatment of intestinal and uterine colics, and should also be valuable in that accompanying the passage of stone.—*Southern Journal of Homœopathy*, December, 1891.

CALCAREA CARB. AND CALCAREA PHOS., if persisted in seem generally sufficient to overcome anæmia and chlorosis. The action does not seem to be interfered with by the use of other remedies as intercurrent for the ever changing and shifting symptoms that are usually engrafted upon these conditions. Indeed the homœopathically indicated remedy seems to act equally well, perhaps better, while the patient is taking the appropriate tissue-remedy as a steady diet.—*Southern Journal of Homœopathy*, December, 1891.

SOME VERIFIED SYMPTOMS.—Dr. C. A. Weirick reports cases verifying the following symptoms:

Sensation as of hair on the tongue, *allium sativa*.

Wants to be rocked, *cina*.

Child cries before urinating, *lycopodium*.

Drinks fall audibly into the stomach, *laurocerasus*.—*New Remedies*, January, 1892.

PULSATILLA IN INTERMITTENT FEVER.—1. Pulse weak and small, often hardly perceptible but quickened; seldom slow; evenings throbbing of the bloodvessels; swollen veins in the evening heat.

2. Chill, coldness and shuddering predominate; constant internal chilliness even in a warm room; chill increased towards evening: chill with the pains; chilliness with overrunning heat: one-sided coldness with sensation of numbness; in the evening cold drawings through the back; evenings and before midnight constant running chill without shuddering; thirst before the chill and before the heat, seldom with either.

3. Heat after the chill, with anxiety and redness of the face; general internal dry heat, without external heat, evenings or nights; heat of the face or of one hand, with coldness of the other, heat of the body with coldness of the extremities; attacks of anxious heat as if hot water were poured over one.

4. Copious sweat in the night or morning; sweat during sleep; soon disappears on waking; easy sweating in the daytime; one-sided sweat, sometimes only on the face and hairy scalp; night sweat with benumbing coma; sweat often smells sweetish, sour or mouldy or like musk, and is sometimes cold.—*California Homœopath*, January, 1892.

PROVING OF ARGENTUM CYAN.—Prover took one-grain dose of 10x trituration at 5 P.M. Instant sensation in left hypochondrium, extending down to left umbilical; never felt before; continuous (*quære*, left colon sigmoid?); then in thirty minutes slight griping in right colon; anal flatus; at 6 P.M. pain amounts to actual

tenesmus, right colon to umbilicus; took a dose of 4x last night, no action being felt then beyond a momentary cutting, but on awakening in the morning had much pain in the nape of the neck and the occiput.

December 3.—Much abdominal flatus passed per anum; anus congested; three doses during the day; in evening, face and body, here, there and everywhere, felt as if gnats were on the surface; dreamt lower part of spine was having melted cast iron poured on it (this must have been from pain); urethral heat; flatus up and down; instant hunger after each dose; pain from spleen to right testicle; sharp, momentary, awful incubus.

January 7.—A dose of 14x proved curative of gastric acidity. Pain in neck followed; also stinging tingling in both feet like electric shocks; further doses resulted in much crackling in bones of right ear, which itched much inside.—*Homœopathic World*, May, 1892.

NAPHTHALINUM 6x cured incarcerated flatus in transverse colon, causing much cardiac distress. The curative action was instantly set in motion, and a similar result always follows a similar dose when needed.—*Homœopathic World*, May, 1892.

SODIUM MERCURIUS AMALGAM 10x.—Three doses caused sudden, severe inflammatory swelling of second knuckle-joint of right hand, pressure upon which in assisting one to move in bed was agonizing; all disappeared in the course of the next morning as suddenly as it occurred; pains in joints of hands, various, always follow one single dose. Nothing of the kind ever felt before.—*Homœopathic World*, May, 1892.

CALENDULA recently cured a fifty years' habitual constipation, the cause of which was located in the cæcum.—*Homœopathic World*, May, 1892.

SCILLA 2x and Amorphous Phosphorus 20x curative in alternation; rapid successive doses in a case commencing in the head as a coryza, which has hitherto every winter been a two-months' job, in three days, the subject exposing herself during the present bitter northeast winds with most daring confidence of immunity. A guiding symptom for scilla's selection was "urinary incontinence during the cough. The action of the amorphous phosphorus on the *bien etre* was little short of marvellous, while sleep (from one or both) became better than had happened during many months previously.—*Homœopathic World*, May, 1892.

CHLORALAMID SYMPTOMS.—Dr. F. G. Oehme remarks concerning *chloralamid* that it produces occasionally headache upon awakening, lassitude and desire to sleep in the morning or throughout the entire day. Unusual symptoms arranged in the order of their frequency are the following; slight or severe vertigo, thirst, nausea, dryness of the mouth, loss of appetite, slight delirium, vomiting, cardiac weakness, rapid and feeble pulse, and restlessness necessitating forcible restraint.

Chloralamid lessens the specific gravity of the urine, often as much as ten points; causes muscular tremors, lessening the co-ordinating power; later on pains all around the joints.—*California Homœopath*, April, 1892.

SUGGESTIONS IN THE TREATMENT OF ECZEMA.—Dr. A. C. Clifton, says that *rhus tox.* and *rhus venenata* hold the first place in the treatment of eczema, more especially when there is much moisture or weeping of the skin, and when there is associated the rheumatic diathesis. The more inflammatory the skin has been, and the more acrid and irritating the exudation, *rhus venenata* has acted better than the *toxicodendron*, more particularly when the rheumatic element has not been very apparent. The author has found the 6x to 12x dilutions of *rhus tox.* more curative in rheumatism apart from the disease under consideration; yet here the mother tincture in one-drop doses has given him the most satisfaction, and *rhus venenata* in the 1x dilution has never given him any aggravation. The next best medicines in the weeping form of the disease, have been *croton tiglium* in 3x dilution, and *cantharis* 3x but where the latter have been found useful, the rheumatic element is either very slight or absent.

Arsenic holds a high place in the treatment of eczema. One or two drop doses of the "*liquor arsenicalis B. P.*" may be given three times a day, especially in neurotic and debilitated patients of gouty tendency, with a dry hot skin, poor appetite, and nocturnal sleeplessness.

Graphites in the 6x trituration comes next in order in point of usefulness, for patients with a dry and cracky skin, who moreover often suffer from constipation, and fissures of the anus, with more or less indigestion, especially when cold drinks cause pains in the stomach, and when in women the menses are pale and scanty in color.

Sulphur is called for, especially in the beginning of the treatment when cold water either internally or externally causes aggravation, as does *graphites*; but where sulphur is indicated there is a dislike to cold water, while where *graphites* is useful there is a desire for it, but the gratification of this desire causes pain.—*Monthly Homœopathic Review*, April, 1892.

TREATMENT OF IMPETIGO.—The medicines that Dr. Clifton has found most curative in impetigo have been *hepar sulphur* 3x to 6x, *antimonium tart.* 6x to 12x, *croton tiglium* 3x, and *mercurius solubilis* 6x to 12x.—*Monthly Homœopathic Review*, April, 1892.

REMEDIES FOR FURUNCULAR AFFECTIONS.—Dr. Clifton has found *apis*, *bella-donna*, *hepar*, *mercurius* and *silicea* most beneficial in furunculous affections at different stages of their development; while in carbuncular conditions *baptisia* and *rhus* in the mother tincture in the early stage, and next in order *mercurius corrosivus* 3x, *lachesis* 10x, and subsequently *silicea* 3x and *sulphur* 3x have completed the cure.—*Monthly Homœopathic Review*, April, 1892.

INDICATIONS FOR TISSUE REMEDIES.—Dr. Alfred M. Duffield gives the following therapeutic hints: *Calcarea fluorica* 6x. For hæmoptysis and bleeding hæmorrhoids; bright red blood, following a short hemming or hacking cough; from over exertion.

Kali Phosphoricum 6x.—For nerve tire and sleeplessness caused by over-exertion; nervous headaches; palpitation from excitement; insomnia from crowding thoughts; one of the best remedies to build up the nervous system after a spell of typhoid.

Natrum Sulphuricum c.c.—In chronic sick headache; begins in the morning on walking, gets worse until noon and subsides about bedtime; can't tolerate noise, has to go to bed in a darkened room, nausea and severe vomiting; takes form of a regular recurrent gastric headache. One case—cured by four doses—recurred every Thursday for over twenty years and has never had one since treatment three years ago. Also valuable in intermittent fever, bilious bloody stool; greenish or bronze colored coating on back of tongue, a very constant symptom; conjunctiva yellow.

Natrum Phosphoricum 6x.—In ophthalmia with profuse creamy, sticky purulent secretion and dim vision, especially in old women; also when accompanied by diarrhœa.

Calcarea Sulphurica 6x.—In phthisical coughs with greenish-yellow expectoration, rattling cough; also in ordinary catarrhal colds and in cases similar to those benefited by *hepar sulphur*.

Ferrum Phos. 6x.—Has such a wild application to the congestive and inflammatory conditions that it is almost universal in all troubles of that nature; has a very marked influence over congestive headaches, especially when at the menstrual period. It might be called a second *aconite*. It is very beneficial in cases of anæmia and seems to give best results after *calcarea phos*.

Magnesia Phos. 6x.—In gastralgia is magic in its effect, often stopping a crampy condition in the stomach in a few minutes where all other remedies have failed. It is beneficial in the colic of horses too.—*Southern Journal of Homœopathy*, April, 1892.

MAGNESIA PHOSPHORICA IN NEURALGIA.—Dr. L. M. English reports the case of Mrs. E., who suffered from neuralgia of the face, mostly on the right side; began soon after becoming pregnant; pain of a very severe character; the attacks would come on toward evening, nearly every day, and last for hours unabated. The following remedies were used with little or no benefit: *Aconite*, *bella-donna*, *colocynth*, and *spigelia*. Finally, *magnesia phos.*, was used with the most gratifying results, as the neuralgia ceased very soon, and there has been no return after a lapse of six weeks.—*Medical Era*, May, 1892.

TWO THUJA CASES.—Dr. A. Uebelacker reports the following cases:

CASE I. Man, 38 years of age, married, suffering from phthisis, was thrown from a wagon with his wife. His knee, elbow, and shoulder were injured, but he helped his wife up, and walked with her a short distance home. An examination showed

a dislocated shoulder and a bruised knee. He made light of the latter. The dislocation of the shoulder was reduced and did finely. In about three weeks the patient complained of great pain in the knee, and upon being called, I found heat and swelling of the joint, with extreme pain. It was a typical case of synovitis. Rest and hot applications were ordered and *pulsatilla* given without relief. To secure absolute quiet, the knee was put in a plaster splint and *apis* administered. This was followed by relief, and in about six weeks the patient went to the mountains. On his return in a month he complained of a good deal of tenderness of the parts, and with every step the patella would slip. Former remedies were tried faithfully, but did no good. *Calcarea carb.*, was given but without success. Upon going back into the patient's history good indications were found, from his youthful indiscretions, for *thuja*. This was given both internally and externally, with rest in bed. The tincture was painted on the knee, and 6x given internally. In six weeks he was well, and remained so.

CASE II. Young man, unfortunate in his associations with prostitutes, applied to a dentist for treatment for a growth between his teeth. Upon examination, the dentist advised him to have a surgical operation performed, as the growth sprung from the bone. He applied to me for treatment, and received *thuja* high and low, but with no result. After a trial of four weeks with no improvement, internal treatment was stopped and *thuja* tincture was applied locally. Improvement began at once and the growth entirely disappeared.—*Transactions of the New Jersey State Society*, 1880-91.

SULPHONAL.—Among the effects observed from sulphonal are the following: Stupidity of mind; paralysis of body; with vomiting, diarrhoea and violent chills. The symptoms disappear slowly. Cold water and cold douches relieve.

The *Lancet* (April 4) notices a series of cases published by Bresslauer, of Vienna. The patients were lunatics. Out of seventy-seven treated seven showed serious symptoms and five died. The poisoning symptoms observed were:

Great constipation.

Dark-brown urine.

Pulse slow—in some cases feeble and rapid.

Discolored patches like purpura on the limbs.

Great prostration.

Death from heart failure and oedema of the lungs.—*Homœopathic World*, December, 1891.

ARNICA RADIX.—Facial neuralgia; left side; face swollen; dark red; very painful to touch; the pupils dilated; bitter taste in mouth; cold nose; very excitable; worse at night; could get but little sleep. "Coldness of the nose" led to use of *arnica radix* θ in water, with cure of patient, and sleep so sound as to make patient believe it was an opiate she had taken.—Lillian H. Dell, Keneshaw, Wis., in *Homœopathic Recorder*, April, 1892.

MERCURIUS CORROSIVUS.—Of the numerous remedies suggested in our materia medica for albuminuria, *acon.*, *apis*, *ars.*, *bell.*, *glon.*, *ver. vir.*, etc., *merc. cor.* easily ranks first in importance. Frequency of micturition, and of a scalding sensation, according to Mitchell, may be complained of before the albumin appears. It is especially useful when the nephritis has been preceded by a coated tongue, sluggish bowels, thirst, sallow complexion, pain in the back, followed by chill and fever, and albuminous urine. In other words, when gastric and hepatic symptoms are first noticed, followed by renal insufficiency.—Dr. E. H. Wolcott, in *N. A. Journal of Homœop.*, March, 1892.

A SEVERE CASE OF IODOFORM POISONING.—Dr. P. Näck, of Hubertusberg, Germany, employed iodoform as a dusting powder in treatment of an eczema on his own person. Eight days after it was begun to be employed, first pure and then mixed with starch, there suddenly set in a confusion of mind which lasted ninety-six hours, gradually wearing off after a very long time. The most prolonged symptoms of this were paraphasia, tremor, agrypnia, hypochondriac depression and a very intense odor and taste of iodoform, which finally reminded one of the odor of ether or balsamics. As only 8 to 10 grammes were used and the doctor resumed his occupation some four and a half months after the beginning of the trouble, there must have been a pronounced idiosyncrasy present.—*Berliner Klinische Wochenschrift*, No. 7, 1892.



THE LATE CHARLES E. LANING, M.D.,

CHICAGO, ILL.

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A STUDY OF CHRONIC AND OBSCURE DISEASES.*

BY C. E. LANING, M.D., CHICAGO.

THE key of this class of diseases is to be found only by making one's self, as nearly as possible, master of the significance of single or individual symptoms. It is, of course, well known that a given symptom may be due to a variety of causes or lesions. This knowledge, together with the ability to ascertain the cause of a certain symptom in a given case, is what enables the practitioner to change an obscure to a plain or simple case. Of course it will at once be seen that "obscure," as applied to disease, is only a relative and not a positive term, since what is an obscure case to one may not be at all so to another. When a case is labeled "obscure," it is an indication of the practitioner's skill, or lack of it, rather than a guide to the nature of the case.

We generally speak of "chronic and obscure" cases together, as if there was some definite connection between them. I never heard of a physician who made a specialty of acute and obscure cases. The longer a disease lasts the more likely are complications to arise, and just in proportion as they do, the case becomes more or less difficult to diagnosticate, in short, obscure. It must be remembered, however, that an obscure case is not necessarily a chronic one, nor the reverse. Therefore, in studying cases coming under these dif-

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ferent headings, there are certain peculiarities belonging to each which must be carefully considered. First we will give our attention to chronic diseases.

It is well known that, as a rule, chronic cases are more or less difficult to prescribe for. There is either a paucity of symptoms upon which to base a prescription, or such a multiplicity of them, that it is quite difficult to select the curative remedy. Let us see *why*, when there are many symptoms present in a chronic case, it should be difficult to prescribe for. It will be found in many instances that the symptoms vary from day to day, or even at different periods of the same day. Now, why should this be; it is certainly not rational to think that the lesions upon which the symptoms depend can or do change every few hours or days. No, they do not, and the explanation of this peculiarity is as follows: Until a disease has passed the point of curability it will almost always be observed that a given symptom or groups of symptoms will represent one might say the two sides of a coin or medal, on which the reverse and obverse side have objects just the opposite one of the other. Thus, on one side is land, on the other water; the difference between the coin and the disease being, however, that in the disease, without turning it over, so to speak, we see one day land and the next day water on the same side. This represents the oscillation or pendulum-like swing of the symptoms in chronic diseases.

Thus nature is always, until entirely overcome, attempting to bring back the disease tissues to a normal state, and, as a consequence, this change in the symptoms, due to action and reaction, makes itself manifest at certain, or rather uncertain, intervals. Now for the application of these facts in practice in the treatment of this class of cases. It is self-evident that all parts of the organism do not react with the same degree of force and rapidity; hence there will be present in the same case some symptoms which may be said to be due to action, others to reaction. Now, the symptoms of reaction have little or no interest for the therapist except that he must be able to recognize them, and not confound them with the positive ones of action. Perhaps this point cannot be better illustrated than by referring to the action of one or more remedies.

In reading the pathogenesis of aconite, you will find that the symptoms all point to a diminution or suppression of almost all the secretions. The urine is high-colored and scanty, the skin hot and

dry, etc. Again, you will find under the same remedy urine profuse and light-colored, profuse perspiration, etc.

Now these latter symptoms are not in the strict sense of the term aconite symptoms, but are those due to the reaction of the nerve centres in their attempt to free themselves from the effects of the aconite or some other urinal agent having a similar action. To carry this point still further, then, the fact must be considered that while the urinary and sudoriparous glandular systems have presented symptoms to reaction (an evidence that medication is not needed so far as they are concerned), nevertheless other portions of the organism may not as yet have been able, unaided, to react, and hence need a remedy to assist them. And now, mark the point, while in taking the case the physician may think aconite cannot be indicated, for the reason that there is not present the hot dry skin, scanty urine, etc., but just the reverse. Closer observation will show that some other part of the organism needs the assistance of this remedy. A further mistake which is liable to be made here is, that the physician being desirous of covering the "totality of the symptoms," attempts to select another remedy corresponding to the skin and urinary symptoms, thus being led into alternating for entirely unjustifiable reasons.

I hope by the foregoing I have made my point clear, viz., that the practitioner must be able to distinguish between the symptoms calling for a remedy and those purely reactionary ones which need no attention at all. In chronic diseases these symptoms of action and reaction, or positive and negative, if I may so call them for want of a better term, present themselves with more or less regularity.

All of this emphasizes decidedly, it seems to me, what has been largely or entirely overlooked in our school, viz., that in almost every case there are present a greater or less number of symptoms which have no therapeutic value whatever, and the physician who does not recognize this fact but who blindly attempts to select a remedy to cover the "totality of the symptoms," will have made a grave mistake. For the reason already given, that is, that all portions of the organism do not react against an inimical agent with equal rapidity and force, certain remedies which are generally considered as useful only in acute diseases are overlooked in chronic cases, where they are, nevertheless, often of great value. Thus I have heard physicians express their surprise at my prescribing aconite, belladonna, and some other remedies for diseases of long duration, because, as they said, these were only good in acute cases.

The fact is, however, that aconite, for instance is a remedy of rare value in some forms of chronic disease, and he who only prescribes it for a patient with a hot, dry skin accompanied by restlessness, anxiety, and suppressed or scanty urine, does not know half the value of this great remedy. In chronic spinal, cerebral, gastric, cardiac, renal, and hepatic diseases, aconite is not infrequently the remedy, it being, nevertheless, often overlooked for the sole reason that the practitioner cannot conceive of its being useful except in an acute case.

A few of the cardinal points necessary to bear in mind in order to treat successfully and comprehensively chronic cases, are as follow: To recognize the chameleon-like changefulness of the symptoms, and not attempt to follow them by a change of remedies. To *always* take carefully the *anamnesis*, and not forget that no matter what new symptoms may have appeared since the onset of the disease, it is always very possible, not to say probable, that the remedy which was indicated at that time, no matter how many years back, may be the curative one at the time of taking the case, although other remedies may seem more strongly indicated.

The last part of this sentence may draw down some criticism, that is, saying that the remedy which seems the most strongly indicated is not. If I had time, I am sure that I could demonstrate that this statement, while apparently paradoxical, is medically correct.

In prescribing for chronic cases, it is of great importance to discover the initial or parent lesion, since, in this way, it becomes possible to distinguish between the therapeutic and non-therapeutic symptoms, a matter of vital importance in correct prescribing. The temperament and habits of the patient must be carefully noted. The periods of amelioration and aggravation, as well as the conditions causing either, must be thoroughly studied, since in this way much light is often thrown upon the nature and location of the lesion to be removed.

I will now say a few words in regard to "obscure" diseases. As I have already stated, this is simply an arbitrary and relative term. The only way I can suggest to lessen the number of obscure cases is, to study diligently and thoroughly the *significance* of symptoms. The students, at one time, named me "Old Significance," because I so frequently and forcibly insisted upon the importance of such study.

An illustration or two of this method of making "clear" an "obscure" case, will serve, perhaps, better than any other way to ex-

plain my meaning. Some years ago a patient, male, aged 36 years, of nervous-sanguine temperament, came to me complaining of the following symptoms: The first thing he spoke of was an almost constant and exceedingly annoying pain between the scapulæ. This pain was not severe, but rather a dull ache, which, on account of its persistence, made him quite nervous and restless. He did not sleep well, not because the pain *per se* kept him awake, but it got him so restless and nervous through the day that it was usually from 12 to 2 o'clock before he could get quieted down sufficiently to sleep.

Now the first thing which came into my mind, was, what is the significance of this pain. And my registering ganglia at once replied, it may be a rheumatic affection of the tendinous fibres of the origin of the rhomboidii, or some lesion of the vertebræ in this region, or of the spinal meninges, or of the cord itself, or some derangement of the stomach, liver, intestines, a pulmonary lesion, a mediastinal tumor or an aneurism of the thoracic aorta. I knew that this persistent dull pain in that region *might* be caused by any one of the conditions enumerated, and that it *must* be due to some one of them. All that was left, therefore, was to discover *which* it was.

Without going into the detail of the differential diagnosis, I will simply state that it proved to be the outgrowth of an aortic aneurism, as was shown by a subsequent *post-mortem*. Now, this was an "obscure" case to me at first, and only for my knowledge of the "significance" of symptoms would have remained so to the end, as it did to several of my allopathic confrères, despite the fact that they were professors in a leading old-school college. These men were present at the *post-mortem*, and remarked, they did not see how that "little pill" doctor diagnosed aortic aneurism. It was an unusual case in some respects and aneurism would not ordinarily have been suspected, and I am sure I should not have thought of it except for the reason that all other causes for the pain failed to materialize.

He who expects to be successful in the treatment of obscure diseases, or rather he who can cause the obscurity to vanish, must be thoroughly posted on "reflexes," and on the "significance" of symptoms, and in order to become so, he must be well grounded in the anatomy and physiology of the other portions of the organism.

As in chronic cases, so in obscure ones, the physician must be competent, to take carefully the clinical history of the patient, following the disease from the first inception up to the stage it has arrived at when first detected by him.

I scarcely feel that it is necessary to ask the indulgence of the Society for the imperfect manner in which I have handled the subject of "Chronic and Obscure Cases," since all know the vastness, the magnitude of the subject and readily realize that a volume rather than a few pages, would be required to deal with it at all exhaustively.

INCURABLE CASES CURED.

BY GEORGE WILLIAM WINTERBURN, PHAR. D., M.D., NEW YORK.

EACH of the cases herewith presented was pronounced incurable by competent allopathic authority. They were doubtless incurable by any therapeutic method outside the domain of *similia*.

I. *Scirrhus of the Pylorus*.—R. S. M., about 50 years of age, a stage-driver by occupation, about two years before I first saw him, had fallen off his seat and had been run over by his own stage, the wheel passing diagonally across the body from the right shoulder to the left hip. Several ribs were broken and he was otherwise injured. He was taken to Bellevue Hospital, where he remained three months. About four months later, that is, seven months after the accident, he began to have cramping pains in the stomach. These became gradually more severe, and after the lapse of several months he began to vomit food about two hours or so after it was eaten. Later, in addition to the vomiting of ingesta, there was coffee-grounds emesis. This was sometimes mixed with the digested food and sometimes was clear. From this time on, and perhaps earlier, he suffered very much from severe lancinating pain in the region of the pylorus. He was treated by various "old school" physicians, by whom the trouble was diagnosed as cancer of the stomach. He finally applied at the Manhattan Hospital (West Twenty-fifth Street), and came into my clinic. His condition then was:

Very greatly emaciated.

Yellowish color of the skin, which was dry, harsh, and wrinkled.

Expression of the face despondent. Mind morose, irritable, obstinate.

The irritability of mind worse after eating solid food, which lies like a stone.

Malar bones very prominent.

Tongue dry and of a dark-brown color.

Great thirst; drinking hot coffee makes him feel better for a time; hot milk also agrees.

Appetite voracious, but afraid to eat on account of food causing pain.

Abdomen sunken; the pulsation of the descending aorta plainly perceptible.

Just above and a little to the right of the umbilicus a hard, irregular lump, about the size of a duck's egg. This lump was movable, and was noticeably lower in the abdomen and drawn toward the left immediately after eating.

Vomiting after eating; of food partly or wholly digested; of coffee-grounds mixture; of a watery, albuminous fluid.

Lancinating pain in the tumor < by eating.

Gurgling noises in the bowels.

Stool, alternating constipation and diarrhœa. The constipated stool was hard, dry and scanty. The diarrhœic stool acrid and watery.

Lower limbs œdematous.

Very weak; knees totter, and he can hardly walk he is so weak.

Great weariness, < by movement. Limbs seem heavy like lead.

Restless, uncomfortable sleep.

General condition < in room > out doors.

Here was apparently a case of cancer (scirrhus) in a very progressed stage. The prognosis seemed hopeless, and the patient himself did not believe anything could be done for him. As he had had much allopathic treatment, I gave him *nux vomica* 6, three doses three hours apart, and *sac lac* for three days. On the fourth day, having again gone carefully over the case, I gave him *bryonia alba* 30, one two-grain powder dry on the tongue every six hours. Within forty-eight hours the vomiting ceased, and only returned at long intervals. In a week his whole general appearance indicated improvement; the pain in the tumor was nearly gone. In six weeks after treatment was begun he ate a dinner of corned beef and cabbage without distress; the tumor was very much smaller than formerly. In four months, tumor all gone; he had gained twenty pounds in weight; bowels regular; skin normal; in fact he was well, except occasionally he would, without any apparent reason, vomit food in a partially digested state.

II. *Pulmonary Phthisis*.—R. C. H., aged 22, son of a wholesale butcher in Fulton Market and himself brought up to the business,

but being addicted to drink and women could hardly be said to have any useful occupation.

The family were in very good circumstances. R. was a graduate of the New York College, and his sister is an "old-school" physician. R. was not vicious, but fond of gaiety and had had four or five years of rapid living. About two years ago he had begun to have a cough which was supposed to be a "stomach cough," and of no importance. His appetite became poor and capricious, as was natural in a man who spent his evenings in carousing. He had, however, none of the outward marks of dissipation. He was quiet in manner, neat in dress, and in fact eminently respectable in appearance. Being endowed with almost phenomenal natural vigor he had been able to withstand his suicidal conduct without showing to the casual observer the ravages which were going on within. For more than a year, however, he had had night-sweats every night, and these had become so severe that he not only saturated his night-shirt but the sheets as well. The cough had become very exhausting, and he occasionally spit blood. He was now thoroughly alarmed and appealed to me for help. Previously to this he had been examined by a well-known "old-school" specialist in lung troubles, who told the family that he was doomed, that nothing could cure him, that a change of scene and habits might prolong his life, but that a cure was impossible; residence for a year in the Adirondack region was advised.

I had known this winsome boy, and as a boy he was indeed winsome, for many years, and was, therefore, very glad to give his case particular care. I found on examining him that the breathing was rapid (30-35) and shallow; much accelerated by even moderate exertion. The temperature in the morning was about normal, or slightly subnormal, and in the evening 100.5° to 101° Fahr., or even 102°. The amount of blood expectorated was small, but bright red in color. The sputa was thick and yellow, tasting sometimes saltish and sometimes sweet, and showing by the caustic soda method elastic fibres of lung tissue. There seemed to be a marked exacerbation of the cough, and other symptoms on alternate days, though there was not much change in the diurnal range of bodily temperature. There was considerable pain in the lungs which seemed deep-seated (not pleuritic), though he told me he had had sharp pains, and a feeling of tightness in the sides of the chest whenever, as he said, he took cold. He was unable to lie upon his back, as it seemed to him impossible to breathe when so doing. He was most comfortable on the right side. His voice, which originally had been

noticeably resonant and musical, had become husky and uncertain. Appetite very poor, bowels sluggish.

A physical examination showed clavicles and scapulars prominent, thorax flattened, respiratory motion uneven, skin pale, loose, and remaining wrinkled when pinched. Heart impulse increased in force, but quite rapid (80-95). There were several small areas of dulness most evident on the right side.

I kept him under observation, and *sac. lac.*, for a week, in order to get a picture of the undisturbed disease. He promised to change his habits, and did so to a considerable extent. That is to say he came home and went to bed at ten o'clock, and he drank very little.

I then gave him *silicea* 1600, three doses three hours apart, and then "no medicine" for one week. He had no night-sweats from the first night, and never did have any more as long as I kept track of him, and that was for six or seven years. His appetite and general appearance was better, but temperature, cough, sputa, and breathing remained about the same. I gave sulphur 30, three doses on alternate days, dry on the tongue, and then "no medicine" for a week. The bowels became regular, the cough somewhat looser, the tertian type of the symptoms more pronounced. As there seemed to be on every other day a marked exacerbation of cough, expectoration and fever, at about four o'clock, I now gave, on the twenty-first day, *lycopodium* 30, a dose every fourth day for one month. Under this treatment the fever entirely disappeared, as did most of the other symptoms, including the craving for drink. The cough became infrequent and not very fatiguing. The sputa whitish, being apparently simply mucus without taste. Appetite very good, and a steady increase in bodily weight of two or three pounds a week.

When he had taken the eight powders of *lycopodium* which I originally gave him, I again put him on sulphur as before, and then gave *lycopodium* 200 (*Carroll Dunham*) once a week for several months. He not only was restored to health, but he gave up his bad habits, went into business (retail butcher, on capital furnished by his father), got married, and became a useful member of the community.

III. *Epilepsy*.—Miss M. S., aged 40, dressmaker, about twenty-two years ago was engaged to be married; the wedding-day appointed. The day came, but not the groom, the result, a "fit," followed by a fever. In the following year, on the return of the proposed wedding-day, she had another "fit," and this was followed by others, the interval becoming less and less between the

attacks and dwindling from months to weeks, from weeks to days, until finally she had, during the past six or seven months, two or three attacks each day. She was a refined, delicate woman; an ideal old maid; as quaint as if she had just stepped out from an eighteenth-century picture. For although she and her sister worked for many would-be-fashionables, she herself dressed with an old-fashioned plainness which was very pleasing. She told me her story with the simplicity of a child, and with a faith in my power to help her (because I had cured a number of her acquaintances of various disorders), which made me solicitous of proving worthy of that confidence. As I was at that time seeing from forty to sixty patients every afternoon in my clinic, I could not give very much time to each, so especially interesting cases were given *sac lac.* and told to come back next day. I did this with her for several days until I had obtained a complete picture of the case, as follows:

Her general health was good; appetite, digestion, bowels, sleep, normal.

The attacks were preceded by a sensible aura, which enabled her usually to walk to her bed and lie down. She, as a rule, slept for some minutes and awoke feeling rather better than before the attack. These were irregular as to time; might occur under any circumstances; even at night during sleep. The spasmodic part of the attack lasted not more than ten or fifteen seconds, and was not severe. During the attack the face was pale. The aura consisted of a fine, prickling, not unpleasant sensation, mainly in the extremities.

The other symptoms elicited were:

Irritability of mind before the attack; great flow of ideas and loquacity after one.

Dryness of the throat.

Frequent yawning,

Pain and stiffness in the limbs, relieved by an attack.

Tremor of the hands.

Itching, stitching pain in the soles of the feet and in the toes.

As will be seen, no remedy was clearly homœopathic. Considering the cause of the trouble, one would naturally turn to *hyoseyamus*; but the symptoms did not point to that remedy, and it was not given. As *agaricus* is said to be good for chorea and epilepsia caused by mental emotions, and as the symptoms did not contra-indicate that remedy, it was given in the thirtieth trituration, two

grains, dry on the tongue, every four hours. She returned in one week with the report that she had had only three or four attacks since beginning the last medicine. The first medicine was, as has been said, *sac. lac.*; and for the benefit of those who might be inclined to think that the influence was purely psychological, it may here be recorded that *sac. lac.* had no effect. She went on having her two or three attacks a day, just the same until she had *agaricus* prescribed for her. The medicine was continued. The next week she had only one attack. She then went about a month before she had another. The next interval was about three months, and after that she had no more. But a new series of symptoms appeared soon after she began taking *agaricus*, and these she had never had before. The epileptic attacks were replaced by somnambulistic ones. She would be eating her dinner, or writing a letter, or walking to church, when she would suddenly lose consciousness. She would, however, go on doing the thing she was engaged in just the same, and just as accurately. As, for instance, if she was writing a letter, or making out a customer's bill, she would finish it, but when she awoke would only remember so much of it as she had finished before the attack came on. Or, if she was eating her dinner, she would go on and finish what was on her plate, and if dessert was set before her she would eat that, and then, perhaps two or three hours after, would say to her sister: "There! I forgot to eat my dessert," not remembering anything that had occurred during the somnambulistic state. If, however, she was on the street when this state supervened, she always turned and went home, but she walked along so naturally that no one ever discovered she was unconscious.

Agaricus was allowed to act undisturbed, and these attacks, like the former ones, gradually grew less frequent and finally ceased.

328 WEST TWENTY-FIRST STREET.

CACTUS GRANDIFLORUS.

BY E. M. HALE, M.D., CHICAGO.

(Read before the American Institute of Homœopathy, Washington, D. C., June 16, 1892.)

Two years ago, at the meeting of this Institute, I made a report on the cactus family. In that report I expressed a regret that no physiological experiments had been made by experts to establish the exact physiological and pathological conditions caused by cactus. Since that report was presented, such physiological experiments have

been made, and I am gratified to be able to present them to this bureau.

An active principle of cactus has been presented to the profession by Mr. Sultan. Dr. Wilcox says that eminent chemists have informed him that it is neither a glucoside nor an alkaloid, and intimates that it may be a form of strychnine, because it affects the spinal cord, excites the reflexes, narrows the bloodvessels, and increases the blood pressure; but this is no reason why it is not the active principle of cactus, as experiments made in France with the tincture give the same results, and an allied species, anhalonium, produces similar effects. The so-called cactina may be the inspissated juice of the cactus, or the residue from an evaporated tincture, as has been suggested. It matters not how it is prepared; it is an active principle, and possesses all the toxic and medicinal properties of the plant. In my practice, in which I have a large proportion of cardiac cases, I have used cactina with better results than I have gained from the tincture. One reason is, I suppose, that much of the cactus tincture sold is not trustworthy, owing to the fact that it is not always rightly prepared. I have tried to ascertain the relative strength of cactina as compared with the tincture. Mr. Sultan courteously answered my inquiries, and informed me that $\frac{1}{33}$ of a grain of cactina is equal to 2 drops of a saturated tincture. Fluid extracts do not differ much from saturated tinctures.

Cactina is soluble in absolute alcohol, and I am now using a tincture made on the centesimal scale, each minim containing about $\frac{1}{100}$ of a grain of cactina. I find this quite strong enough to act curatively upon the heart in 2-minim doses (on disks, each one of which contains 2 minims); in cases of functional disorder, where there are structural changes, as aortic insufficiency, or rupture of compensation, 5 or 10 drops give better results. The history of cactus affords a good illustration of the conservatism and prejudice of the dominant school. When it was first brought to our notice by Dr. Rubini, of Naples, about the year 1860, as a powerful cardiac remedy, it was looked upon by his colleagues, for a time, with a good deal of doubt. His claims were so extraordinary that we were slow to accept them. In 1878 I wrote in my last edition of *New Remedies* that it was "doubtful if cactus has come up to the claims made for it by its discoverer." At this writing, many of these doubts have disappeared.

For twenty years after its first use by our school, the eclectic and regular schools sneered at the "fanciful claims of the homœopathsists,

who regard cactus as a great heart remedy." About the year 1876 the leading eclectic physicians began to use the drug, and soon their journals teemed with its successes. They used it, however, in larger doses than we had dared to.

About the year 1879 some of the prominent physicians of the regular school began to use it. One of the first to try it was that Nestor of western conservatism, Dr. N. S. Davis, of Chicago. He reported a case that ought to go on record as the first treated and reported by one of his school with cactus. He began by saying: "The reading of a paragraph in some medical publication (?) concerning the influence of the fluid extract (?) of cactus," etc. He gave it to a lady that had been a victim to the morphine habit, whose "most distressing symptom was cardiac palpitation during the early morning hours."

He gave 4 to 5 minims every two hours, and cured her. A brief comment will suffice. In 1879 there was no "fluid extract" of cactus made. The only preparation procurable was the standard homœopathic tincture, and the only medical journal he could have seen any mention of cactus in would be eclectic or homœopathic. Parke Davis & Co. were the first to make a fluid extract, in 1884, and their label is the following, with indications taken from our text-books on materia medica:

"CACTUS GRANDIFLORUS.

"Properties.—Sedative and diuretic; especially useful in functional diseases of the heart, attended with much irregularity of action, in which it exerts a decided action, palliating or removing the symptoms and frequently giving prompt relief. It has been found serviceable in palpitation, angina pectoris, cardiac neuralgia, rheumatism, valvular disease; also of hæmoptysis, dropsy, and in threatened apoplexy. Its value in the disturbance of functional and organic cardiac diseases is established, but further investigation is required to demonstrate its usefulness in many other maladies for which it is recommended.

"Preparation.—Fluid extract of the fleshy branches with flowers. Dose, 10 to 30 minims (0.65 to 2 c.c.)."

In 1883 a Dr. Bird reported some cases of cardiac disease and acute muscular rheumatism treated successfully with cactus. This, and the case by Dr. Davis, were the first that appeared in the "regular" medical journals. Now, during the last six or eight years, their journals are full of cactus, and they are far more enthu-

siastic than we were during the first years of our use of it. It will be observed that they are successful with large doses—from 5 to 40 drops—of the tincture (!) without any unpleasant result. What would this teach us? I answer, that they use it to get its physiological or secondary effects, in which such doses are necessary, just as large doses of *digitalis* are. When we use it homœopathically, we properly use minute doses, since we usually prescribe it for its primary symptoms as given by Rubini.

Now, by the light of recent experiments, we have in *cactus*, as in *digitalis*, *adonis*, *convallaria*, and other cardiac medicaments, a two-edged sword, which we can wield with greater efficiency than before, and—according to my law of primary and secondary action and the resulting law of dose—without departing from the law of *similia*. I can report that Mr. Sultan and other chemists are working on other specimens of *cactus*, and will probably give us in the near future some valuable alkaloids or glucosides from them. I will now present several papers relating to the physiological and clinical effects of *cactus grandiflorus*.

The following is from the *Therapeutic Gazette*. "Cactina is claimed to be the proximate principle of *cereum grandiflora*, and has been isolated by Mr. Frederick W. Sultan, and forms the basis of a paper published by Dr. O. M. Myers in the *New York Medical Journal*, for June 13, 1891. Dr. Myers finds that locally, cactina is absolutely non-irritant, a 10 per cent. solution applied to the conjunctiva producing no noticeable effect. Therapeutic doses, in man and animals, produce acceleration of the pulse and a rise in the arterial pressure. Toxic doses, in animals, produce primarily an acceleration of the pulse rate and a rise in the arterial pressure, but, secondarily, notably diminish both. The cardiac pulsations become arrhythmical and finally cease, the heart being arrested in systole; the systole just before death becomes very incomplete, probably due, as will be shown below, to a condition of super-irritability of the cardiac ganglia. Death is preceded by tetanic and clonic convulsions, due to over-stimulation of the motor side of the spinal cord. That the convulsions are not of cerebral origin is evident, as they occur after section of the cord in the upper cervical region. The motor nerves remained unaffected, for, after the death of the animal, galvanization produces contraction of the muscle. Cactina is therefore a powerful motor-spinal stimulant. In a dog, after section of the vagi, the pulse rate and arterial pressure were both increased by an injection of 2 centigrammes of the drug, and a strong faradic current,

when applied to the nerve (vagus), failed to arrest the heart's action. After section of the pneumogastrics and sympathetics an intravenous injection of 3 centigrammes of cactina still maintained a decided rise in the arterial pressure and an acceleration of the pulse rate. A fair conclusion therefore, is that the drug produces these effects chiefly by direct stimulation of the intracardiac accelerator ganglion. In the dog after an intravenous injection of cactina, the heart rate was increased from 180 pulsations a minute to 222 a minute, and the cardiometer, indicating normally a height of 145 millimetres, showed an increase of arterial pressure by a rise of 58 millimetres. If an animal is placed under the influence of cactina and the cardiometer applied, the blood pressure, as before stated, will register about 198 millimetres. Now if the spinal cord is cut high up, thereby intercepting the impulses from the medullary vaso-motor centre, the arterial pressure will instantly drop about 20 millimetres. This would indicate that the increased pressure was not wholly due to increased cardiac action, but a result of stimulation of the vaso-motor centre in the brain. The following is the author's summary of the effects of cactina in therapeutic doses:

"(1). Increases the musculo-motor energy of the heart, probably through its influence upon the intra-cardiac motor and accelerator ganglia, in consequence of which the cardiac impulses become regular and much stronger. (2). Elevates the arterial tension, increases correspondingly the height and force of the pulse wave. This is produced by—(a) increased cardiac action; (b) stimulation of the vaso-motor centre at the base of the brain. (3). Influences the nervous system by its direct action upon the motor centres of the spinal cord, thus increasing the reflexes and elevating the general nervous tone. Herein cactina resembles strychnine, and other points of similarity are evinced by clinical observation.

"*Therapeutics.*—It logically follows, if conclusions as to its physiological action are correct, that in cactina we have a powerful cardiac tonic stimulant. Clinical observation teaches that its greatest value is manifest in functional disturbances of the heart, as simple dilation and cardio-muscular atony (resulting from deficient innervation and nutrition) without organic lesions. If valvular disease exists, accompanied by dilatation, the drug would seem to be clearly indicated. In conditions of cardiac and general muscular relaxation with impaired nerve energy, and in cases of "irritable heart," "tobacco heart," etc., the drug accomplishes excellent results; probably by (a) stimulation of the spinal motor nerve centres; (b) constantly

stimulating the heart muscle to action and thereby increasing its nutrition and development.

"A special indication for its use is during the critical periods of adynamic fevers, as it combines the elements of a heart and spinal motor stimulant. Finally, it is stated in *Practice* for May, 1892, that, unlike digitalis, cactina may be administered continuously without fear of exciting gastric disturbances, and the objectionable cumulative action of the former drug is entirely wanting. In short, cactina may be employed with benefit in all varieties of functional cardiac and circulatory disturbances and in organic heart disease, except in cases of mitral stenosis, where digitalis is to be preferred on account of its power of prolonging the diastolic period thus affording the ventricle power and time to entirely empty itself.

"Per contra, in aortic insufficiency, the short diastole produced by cactina allows no time for regurgitation of the blood into the ventricle; whereas, digitalis favors, by prolonging the diastolic period, just what we would seek to prevent."

I will quote another experimenter who confirms the observations of Dr. Myers. Dr. E. Boinet, of France, terminates an elaborate experimental study as to the physiological action of cactus and its active principle with the following conclusions (*Bulletin General de Therapeutique*, October 30, 1891): "In ten minutes after the injection of the first dose in frogs the cardiac energy increases, but this systolic increase in energy is transitory, although it may be continued with the repetition of the dose. With large dose the pulse is slowed, and the final period of the poisoning, is accompanied by disturbed rhythm. Cactina is further stated to produce the stimulating effect on the heart in a more marked and more permanent degree than the extract of cactus, and, unlike the latter, does not lead to slowing of the pulse. In his clinical experiments the author found that 40 drops of the tincture of cactus are without effect, although in cases of disturbed compensation in various forms of heart disease, 80 to 100 drops acted as a valuable cardiac stimulant. (It must have been a poor tincture).

In cases of nervous disturbances of the cardiac rhythm, 80, 100, or 120 drops were given daily for weeks at a time, and are said to have greatly improved the regularity of the heart's action without the production of any evidences of accumulation."

We have in the foregoing, incontestable proof of the trustworthiness of our provings and clinical experience. It will be remembered that I presented to the American Institute, in 1890, physiological

experiments made by Prof. Lewin with a member of the cactus family, *anhelonium*, which experiments resulted in establishing the fact that this species caused effects on the spinal cord, similar to strychnine. I believe all the cacti are spinal stimulants and irritants, as well as cardiac medicaments.

Dr. John Aulde, of Philadelphia, who has recently attained a good deal of notoriety by appropriating our remedies and adding them to the "regular" materia medica, without crediting us with their introduction, writes as follows :

"Cactus grandiflorus is a remedy which has recently been brought prominently to the attention of the medical profession through the publication of a large number of reports from physicians, and as these reports correspond so closely with my own experience with the drug, I have deemed them of sufficient interest to warrant the preparation of a synopsis. Two preparations found in the market are the fluid extract and the tincture, both of which are freely miscible with water. According to my own observations and the reports of those who have used the drug, the dose of either ranges from 5 to 10 or 15 drops, although the dose of the fluid extract is not given at such short intervals as the tincture. Gregory, who has used the tincture for more than fifteen years, recommends 5 drops every two, four or six hours, but the fluid extract need not be given oftener than three times daily. A new preparation, cactina, has lately been advertised in the journals, which is probably an evaporated fluid extract, as it is offered in the form of pellets. While it is quite possible to prepare cactus in this form, there are the accompanying dangers of defects, due to the method of manufacture, and it should not cause the rejection of the remedy should this new product fail to afford the results claimed for the other preparations. Cactus is distinctly a cardiac tonic, free from the so-called cumulative active action of digitalis, and less objectionable to the palate than either nux vomica or strophanthus. It carries with it no narcotic effects, nor does it produce any material constriction of the arterioles, while it appears to possess valuable properties in regulating the movements of the heart, whether the irritability be due to "nervousness" from reflex causes, or to the presence of organic changes, features which will be developed more fully in the course of this review.

The remedy has proven serviceable in the treatment of dilatation with hypertrophy, accompanied by a murmur, in which case we may assume that the dilatation has increased more rapidly than the hyper-

trophy. In cases of palpitation, such as frequently occur as a sympathetic functional disorder due to uterine troubles, or that which is a factor in indigestion with a relaxed (flabby) condition of the system, in which formication is a prominent symptom, cactus is indicated. These patients, when females, often complain of metrorrhagia or menorrhagia, and usually suffer more or less at the catemenial period. While cactus may be useful as a temporary expedient, it should be conjoined with other treatment directed to the stomach and the uterus. Thus, in the case of a disordered condition of the stomach, it may conveniently be combined with the digestive ferments instead of strychnine or nux vomica. Where we have to deal with menorrhagia and other uterine affections, it may be safely and advantageously added to a prescription containing cimicifuga, ergot, or, in the case of leucorrhœa and endometritis, with or without subinvolution, it will be found beneficial to alternate it with calcium sulphide, to which should be added local treatment in the form of medicated tampons.

Not infrequently in young women, and in those who are married, we meet with palpitations which appear to be purely nervous, where it will be found that digestion is at fault, manifested usually by insomnia, although they take their meals regularly. In these cases diet must be regulated and certain objectionable food substances prohibited, generally the starchy and fatty foods and sweets. Moderate exercise must be insisted upon, and proper attention given to the function of excretion. If the skin be dry and harsh, the indication may point to the use of arsenic, rhus toxicodendron or pilocarpine, all of which favorably modify digestion while they promptly influence the activity of the skin. In the case of dilatation, with anasarca and œdema of the extremities, with or without valvular disease, when there is apparently no sufficient reason for the persistence of the disorder, and when digitalis, diuretics and cathartics fail to produce improvement, cactus promises to effect good results. This is the class of cases in which Bartholow recommends the employment of arsenical preparations, and occurs for the most part among persons advanced in years, where there is more or less atheromatous degeneration present, and where alcoholic preparations of digitalis result finally in bringing on sudden collapse and death. An examination of the urine shows an absence of albumin, although the specific gravity may be low; but, as a rule, the signs are negative. Here, evidently, is an indication for the addition of cactus to the arsenic,

and, if there be a demand for catharsis, we have in apocynum an admirable remedy.

Dr. O'Hara has reported several cases of hypertrophy, with dilatation and mitral insufficiency, in which cactus proved efficient after the failure of digitalis and other drugs. Dr. A. Orlando Jones (*Brit. Med. Journ.*, 1890) thinks cactus best adapted to the asthenic conditions, while he approves of digitalis in sthenic cases. Byrd recommends its use in subacute and chronic rheumatism, and in these instances it will be found advisable to combine it with rhus tox. or with cascara when there is a distinct indication for the employment of a laxative aside from the action of the drug upon the heart.

The value of *cimicifuga* should not be overlooked in these cases, as it will prove an acceptable adjuvant to cactus, and, besides, it is a useful drug in nearly all forms of rheumatism.

The cardiac irregularity and exhaustion due to morphine or chloral is promptly relieved by cactus. When these drugs are suddenly withdrawn from those accustomed to their use, it will be advisable to combine with the cactus moderate doses of fluid extract of coca and strychnine, and in quite a proportion of the cases the addition of *cannabis indica* will prove serviceable. Cases of sexual exhaustion are remarkably benefited by the exhibition of cactus, doubtless because it lacks those peculiarly stimulating properties which it is so important to avoid. We are beginning to learn and understand that over-stimulation is always followed by a period of depression. The action of cactus in these cases may be appreciably increased by the judicious exhibition of *nux vomica*, *damiana*, and *phosphorus*.

We are confronted with patients who suffer from exhaustion, with irregular or intermittent pulse, due to the abuse of tobacco; and here, instead of unpalatable remedies like *nux vomica*, we have cactus, which is rather agreeable than otherwise to most persons, and the effect upon the system and the circulatory apparatus is quickly apparent. The patient should take 5 to 10 drops three times a day. The same treatment is indicated for the relief of a similar condition, which often affects those accustomed to the inordinate use of tea. The active principle, theine, it has been found, will cause the heart to intermit, but in cactus we have a drug which meets this emergency, although I do not hesitate to say that the use of tea should be discontinued and coffee or cocoa substituted. The intermittent heart, from the abuse of tea, accompanied by indigestion, with flatulency due to fermentation of food, may be greatly benefited by the alteration of *gelsemium* with cactus, with a view to relieve undue ten-

sion and favor the re-establishment of the secretions. Dr. Gregory, of Yreka, Cal., believes cactus to be more valuable than digitalis where dilatation has outstripped hypertrophy, and says it is the only remedy he uses in functional valvular disease. Dr. Engstad, of Grand Forks, Dak., says: "I now depend upon it (cactus) in preference to digitalis in functional disorders," but complains that many of the preparations are unreliable (*Therapeutic Gazette*, September, 1890). He records its successful employment as a cardiac tonic in typhoid fever after the failure of strychnine and digitalis, and my own experience confirms his report. Although aware that digitalis preparations enjoy a well-merited reputation for the relief of heart troubles, I am of the opinion that many of the cases of sudden deaths from heart failure may be traced directly to the injudicious employment of the drug; and I think the medical profession will hail with delight the appearance of a remedy which will, in a great measure, take its place, and bespeak for cactus a favorable reception and careful study.

Barring the absurd polypharmacy of Dr. Aulde, his use of cactus is rational. If he would be content to alternate it with one medicine, his prescriptions would be more in accordance with the modern practice of his own school. I can verify his recommendations as to the curative sphere of cactus, and while I am sorry to go counter to the practice of most of our school in the matter of dose, I cannot omit asserting that I have had better success with the tincture than with the dilutions.

Dr. C. L. Gregory, of Yreka, Cal., gives the following experience with cactus: "Heretofore I have used it principally in chronic diseases, but during the past two years have used it in continued fevers where the pulse was especially rapid and weak. The effect of the remedy in these cases has been very satisfactory, the pulse almost invariably becoming slower and the heart gaining in power. I am now treating two cases of cardiac dilatation, with anasarca and œdema of the lower extremities, in one of which there is valvular disease with dyspnœa, and in both of which the swelling of the feet and legs was enormous. Digitalis, diuretics, and cathartics had no permanent good effects. I gave each case tincture of apocynum alone, with but temporary benefit. I then gave each of them cactus and apocynum, 5 drops of each tincture in dilution, since which time the improvement has been rapid and steady. They have now been using these two remedies two months, and the swelling has almost entirely disappeared, while in one case the dyspnœa is very much relieved, so much

so that the patient can lie down in bed to sleep instead of sitting up as formerly. These patients are 70 and 64 years old respectively. I have found cactus an admirable remedy in many cases of cold extremities, depending wholly or partially upon a debilitated condition of the system, following upon sexual excess of many years' duration. In some cases of weakened or failing memory, depending upon nervous debility, cactus has been of much value."

Dr. R. W. Wilcox, of New York, has used cactus in his clinics, and makes a report which is very favorable. His observation of its action in several cases, which accompany the report, enables him to arrive at a definite opinion of its physiological action. He says: "The physiological action of cactus is upon the intra-cardiac ganglia and accelerator nerves, through the cardiac plexus of the sympathetic system, and there is no interference with the inhibitory nerves, nor indeed, does its administration produce any very marked vasomotor changes. It shortens the ventricular diastole and increases the blood-pressure. These facts in its physiology have been kept in mind in selecting the cases in which it has been employed. The conditions in which cactus is especially useful are:

(1). Cardiac weakness when the heart has not acquired compensation for the valvular lesion, or, having been compensated, muscular degeneration has taken place so that no relative incompetency exists. In other words, where a pure cardiac stimulant is required, cactus is indicated. Such cases are cardiac weakness in convalescence from typhoid fever, when change of position induces syncope, angina pectoris of purely cardiac origin and of asthenic hearts; simple eccentric cardiac dilation, such as is found in pericarditis from paralysis of the cardiac muscles underlying the area of pericardial inflammation.

(2). The functional cardiac diseases resulting from tea, coffee, tobacco and alcohol, the palpitation of dyspepsia, neurasthenia of the climacteric, exophthalmic goitre, morphinism, sexual exhaustion, and to a less extent, those of anæmia, are relieved; some of these cases being those of purely functional disturbance, atony of cardiac muscle from deficient innervation, others being true degeneration of cardiac muscle and thus belonging to the first class. There are the irritable hearts when palpitation is of emotional origin; these are the cases where cactus makes the pulse regular, because through its action upon the sympathetic the nutrition of the heart is improved.

(3). The "slow" hearts, when there is over-stimulation of the pneumogastric, or marked degeneration of the muscular wall of the

ventricle. These are the hearts formerly so refractory to treatment, the heart in which digitalis is absolutely contraindicated. In all cases the tension of the pulse is increased, but its breadth is unaltered, so that the work of the heart is not made greater by contraction of the arterioles, as is the case in the administration of digitalis. This increase of tension is due to the fact that more blood is propelled through the arteries under the influence of cactus, and the increased arterial tension results in prompt relief of venous congestion. In old rheumatic hearts pain is relieved because this pain is merely a symptom of a heart that is relatively incompetent, and the tonic effect of cactus is to relieve this incompetency; and this is the guide to its administration in valvular lesions. In mitral stenosis, however, it is absolutely contraindicated; owing to the shortening of the diastole, sufficient blood cannot flow into the ventricle to result in an efficient ventricular systole. In aortic regurgitation, however, it is the drug par excellence, because the marked shortening of the diastole regurgitation into the left ventricle is lessened. In other words, in aortic regurgitation, cactus is indicated and digitalis is absolutely forbidden; in mitral stenosis cactus must be avoided, while digitalis should be administered, the one drug having its use when the other would be harmful. In other lesions the guide for administration lies in the relation which the propelling force bears to the work that it is called upon to do, and success in the administration of cactus means a disappearance of symptoms of cardiac insufficiency; I believe that in the intelligent use of cactus in suitable cases we shall achieve greater success than with almost any other drug in common use for diseases of the circulatory system. But the drug will be valuable only to him who obtains a complete record of rational signs, makes a careful physical examination, and bases his diagnosis upon an impartial discussion of all facts bearing upon the case. While cactus will not relieve a very incompetent heart, such as is found in mitral regurgitation when the walls of the ventricle are thin from fatty degeneration and dilatation, yet it is frequently useful; and because it is safe, not cumulative in its action, we can employ it when digitalis might do injury. Cactus, then, acting upon the accelerator nerve of the heart, upon the intra-cardiac sympathetic ganglia, decreasing the length of the ventricular diastole and stimulating somewhat the spinal vaso-motor centres has a sphere of action peculiarly its own. It cannot take entirely the place of the digitalis or aconite group, but it is useful in many cases when these drugs are not only dangerous but absolutely contraindicated. My

own studies lead me to believe that in well chosen cases, following the indication given above, it is a very valuable drug, and one whose place cannot be filled by any other pharmaceutical preparation."

Dr. Wilcox's assertion that digitalis is "absolutely contraindicated in slow heart," will seem strange and irrational to homœopathists, who know that digitalis will restore a slow heart to its normal rate, if given in small doses. From Dr. Wilcox's standpoint, however, he is correct, for the doses he considers medicinal would slow a heart until it was arrested in fatal tetanic systole.

THE TREATMENT OF EPILEPTICS.

BY CHARLES S. MACK, M.D., ANN ARBOR, MICHIGAN.

(Read before the American Institute of Homœopathy, Washington, D. C., June 14, 1892.)

I SHALL assume that matters of hygiene will be attended to, and shall present under the following headings the little I shall say as to the treatment of epileptics: 1st. Surgical treatment. 2d. Palliative medical treatment. 3d. Homœopathic treatment.

An opinion upon a distinctly surgical question is proverbially apt to be conservative. Such an opinion is the one I express, and it is offered simply for what it is worth. Minor operations (such, for instance, as some which have as their immediate object the removal of peripheral irritations), may be undertaken without apprehension, and often with a considerable hope of benefiting the patient. My impression is that major operations are at present too frequently done upon epileptics, and that the promise of benefit is not sufficient to justify such operation, unless the indication is an unusually clear one.

Of the various attempts at palliation, that with the bromides is the only one upon which I shall here comment. I doubt if the practice is ever a good one. I think that very many physicians not homœopathists are entirely dissatisfied with the bromide treatment of epileptics. The *Times and Register* for April 16, 1892, quotes the *Detroit Em. Hosp. Rep.* as follows: "How about the treatment of epilepsy with bromides? Who knows when they are the cause of death? In each of the fatal applications of the treatment before mentioned, the patients had been saturated with bromides until their tongues were œdematous and their digestive juices were inert. A

note of warning against the use of bromides in epilepsy ought to be sounded for the benefit of the neurologists who can see no virtue in surgery for epilepsy, for surely any one who will take the trouble to observe knows that the bromides kill more than they cure.

"Surgeons should be careful to see that the baneful effects of the bromide treatment have vanished before submitting an epileptic to the operation of trephining."

I have seen nothing and read nothing impressing me that anything very startling has been accomplished for these patients by homœopathy. It seems to me, however, that, aside from hygienic measures, and from occasionally indicated perfectly safe surgical methods, usually the most promising course we can pursue is to search for the remedy most homœopathic in a given case, and to try it in various dilutions and attenuations. We shall here attempt little as to what remedy should be given beyond the always safe generalization, *give the remedy indicated*. We shall, however, remark that, so far as the simple fact of epileptic convulsions has weight as an indication, the following named drugs seem particularly worthy of farther study. *Artemisia absinthium* (it is said that frequently those addicted to absinthe drinking become epileptic), *agaricus muscarius*, hydrocyanic acid, *cocculus indicus* or the ingredient picrotoxin found in it. In this connection let me quote from *Bartholow's Hypodermatic Medication*, 5th edition, pp. 422 and 424: "It is asserted that toxic complexus of picrotoxin is a repetition of the epileptic paroxysm. It is known that the several stages in the course of the poisoning and in the course of the epileptic state are practically the same. . . . *Epilepsy* in subjects of a depressed and anæmic kind, especially if nocturnal in time of seizure, is not infrequently much improved by the persistent use of picrotoxin. The affinity of the morbid process set up by picrotoxin with the symptomatology of the epileptic and epileptiform paroxysms is such as to indicate the existence of an antagonism between them, and on this basis Cherone and Tasta have made trials of this remedy with apparent benefit."

LARYNGISMUS STRIDULUS CURED BY FORCED DILATATION OF THE GLOTTIS.—Constantin Paul (*Revue des Maladies de l'Enfance*, January, 1892), reports the case of a child, fourteen months old, who, for three successive nights, so urgently suffered from laryngismus stridulus that the question of tracheotomy was seriously discussed. As a substitute for this grave remedy, the author suggested forcible dilatation of the glottis, which could be practiced with a pair of polypus forceps having a convenient curve. The operation was easily done with the dilator of Laborde, and after this no further paroxysms occurred.

A PLEA FOR THE MORE FREQUENT USE OF COCAINE IN MAJOR OPERATIONS.

BY CARL V. VISCHER, M.D., PHILADELPHIA.

AFTER a series of observations, I feel confident of the fact that we owe, in a great many instances, the shock following operations of greater magnitude to the effects of etherization, and not to the operative interference.

Especially does this apply to individuals who have passed the middle line in life, when the tissues are undergoing their natural metamorphosis. This is all the more readily understood when we remember the direct changes brought about by the inhalations of either ether or chloroform, which consist principally of fatty degenerations of the various organs; thus the great prostration following operations can be traced directly to the effect of ether plus the senile debility. I have repeatedly noticed this in old men, where the magnitude of the operative interference stood in no ratio to the shock that followed. Examination of the bladder under ether has been succeeded by such excessive shock as to seriously question the outcome, and this, too, in patients who were enjoying comparatively good health. This has led me to the more frequent use of cocaine in typical operations, and especially those in connection with the genito-urinary apparatus, where complications could, with reasonable certainty, be excluded.

Fully appreciating the fact, however, that in dealing with this we have to do with a most potent poison, therefore demanding quite as much, if not more, care in its administration than ether or chloroform, but in which we have, if given with necessary precautions, the lesser of two evils, inasmuch as its after effects are but slight and comparatively unimportant. There certainly may be arguments brought forward against the use of cocaine in many operations, but after a considerable experience I would urge its use in many instances where we are accustomed to administer ether, and especially in such cases where complete relaxation is not absolutely necessary. Of a considerable number of cases where I have used it successfully the following are probably the most interesting:

CASE 1.—J. T., æt. 86, a patient of Dr. T. Reading, suffering from vesical calculus, which was removed through the supra-pubic route, after first injecting the tissues in the line the incision was to be made with a 4-per cent. solution of the hydrochlorate of cocaine; the only pain experienced was at the time the bladder, which was much hy-

peritrophied, was opened, and during the delivery of the stone, which weighed 200 grains. I feel confident that both these procedures would have been painless had the interior of the viscus been cocaineized with a weak solution and the bladder wall injected prior to being incised. Although more than a half-ounce of the solution was used, aside from some mydriasis and loquaciousness, no physiological symptoms were produced; the former of these has been observed in almost every case, no matter how small a quantity was injected. The patient made a rapid and satisfactory recovery, there having been but a very slight degree of shock following the operation.

CASE 2.—J. N., æt. 54, weighing considerably over two hundred pounds, has been subject to repeated attacks of retention, due to a stricture in the deep urethra which admitted, after some difficulty, a filliform; owing to the fact that he was an old bronchitic, I hesitated in the use of ether and was prompted to use cocaine in spite of the very deep perinæum.

A 4-per cent. solution was injected in the raphæ, after which the needle was introduced directly through the perinæum to the urethra, depositing drop for drop as it was gradually advanced. The division was made without the slightest pain; even the introduction of a large-size sound was painless until it entered the bladder. A little over two drachms was required. The temperature rose to $99\frac{2}{3}^{\circ}$ on the following day, after which it returned to normal, the patient attending to his business in less than a fortnight following the operation.

CASE 3.—J. H., æt. 77, suffering from a traumatic stricture in the bulbous urethra, with a purulent cystitis; perineal section was done in the same manner as described above, with but little pain, the pain occurring as in the foregoing instance, when the finger was introduced into the bladder for exploration.

These may serve as examples in which cocaine was used with considerable satisfaction; so much so, indeed, that I should not have the slightest hesitancy in using it in some of the abdominal operations, such as colotomy, or even in uncomplicated ovariectomies, as I have, on one occasion, employed it with the best effects in a case of strangulated hernia.

CAMPHORIC ACID has been recommended as giving rapid and permanent relief in *acute coryza*. A woolen tampon is charged with a two per cent. solution and introduced into the nostril.—*Merck's Bulletin*, February, 1892.

WHAT IS MENTAL ALIENATION?

BY J. D. BUCK, M.D., CINCINNATI.

(Read before the Ohio Homœopathic Medical Society, May 10, 1892.)

IF the title of my paper were taken as a conundrum, and an answer were demanded on the spur of the moment from every physician present, and the answer in writing, so that no one could get a clue from another, the answers would no doubt surprise us from their diversity. Doubtless some would "give it up," and unless one has studied the subject a good deal, and thought it over a good deal more, it were wiser to give it up than to give an answer that had not been carefully thought out, and that therefore could not long be defended. Our definition of mental alienation must, of course, depend upon our idea or definition of mind.

It would, no doubt, prove tiresome to those unfamiliar with and disinclined to metaphysics to go into a critical examination of the various definitions of mind found even in Webster's Unabridged. Webster himself defines mind as the "rational faculty, the understanding . . . also the entire spiritual nature, the soul." This is certainly broad enough to include all definitions. Webster, however, quotes Reid as saying that "mind in man" is that in him which thinks, reasons, wills; and Sir William Hamilton as saying, that "mind is that which perceives, thinks, feels, wills and desires." Now confusion is here manifest between the thinking principle and the *thinker*, and by making mind synonymous with "the entire spiritual nature, the soul," is to render the whole subject still more obscure, and language more indefinite and contradictory. To call mind "the entire spiritual nature, the soul," and to leave these undefined, is merely to jockey with words.

A great many persons, and among them many physicians, turn away from all such discussions as being hopelessly obscure and metaphysical. Metaphysics is neither more nor less than the true philosophy of physics, and the connection that the physical universe bears to its motor power and plan of action. Therefore, there can be no understanding of physics without metaphysics. In other words, physics, viewed from the mental plane, becomes metaphysics. The reason why such obscurity and confusion is found in these subjects is because idle speculation and dogmatism, and, above all, a gross materialism, have been allowed to take the place of true phi-

losophy. All of our so-called psychology is mere guess-work and empiricism proceeding from the material plane. Mind, and even consciousness, are regarded as mere functions of organized matter; and it has even been declared that "the brain secretes thought just as the liver secretes bile." If this were true, and thought were an inert secretion like the bile, how could it create a world of its own? Not only an actual world of life and action, but also an ideal world far beyond our present realization. Such a statement, therefore, is not only without the least science or philosophy to justify it, but it is devoid of sense or reason. A true philosophy of mind is not obscure or difficult of apprehension. All obscurity in this realm belongs to ignorance, superstition and dogmatism.

There is diffused throughout the boundless universe a *thinking principle*. This is not an extra-cosmic personal god, but an intra-cosmic intelligence or universal mind. This is like saying that a principle of life or of force or power is diffused through every atom of matter in all space. This thinking principle or universal mind is the source or fountain from which springs what we call mind, thought and consciousness in man. If, now, we analyze mind in man, we find, first, the thinking principle, which determines the laws of thought everywhere. Second, the thinker, the self-conscious centre in man. Third, the thought itself, or mental picture, which, according to its range and completeness, is an epitome or miniature of the "thought divine" or universal mind. Fourth, there are the conditions and laws of thought which, under universal law, determine the character, range, power and effect of thought; and fifth, there is the result of thought in action, or what is called the thought form. Let us imagine a city, with all its surroundings and appurtenances, like Cincinnati, for example, to be photographed within a space the size of the crown of a hat in such a way that every detail should be preserved perfectly, and so that a powerful glass would bring it into clear view. This might be called an epitome or miniature of Cincinnati, and this is quite conceivable. Now, let us call Cincinnati the world, and the brain-pictures produced by conscious thought, the photograph. There is this difference, however: The photograph is a picture only; it represents only the *appearance*, the outside, and not the actuality. Therefore, our illustration is only partial, and our photograph is an apparition, not an actuality. Let us start again, Cincinnati still representing the world; let us imagine it as condensed to the size of our photograph, yet preserving every attribute, so that instead of an image representing only its appear-

ance on the outside, it is the city (or the world) outside, and inside with all its qualities, potencies, activities and moving sentient life. Our photograph has now become alive, and actually epitomizes the city or world in miniature. This is the reproduction of the world in whole or in part in the realm of conscious thought. It is thus that man creates in thought, or reproduces the forms of nature and of life from patterns already existing in the universal mind. The thought-forms created by man are not passive and lifeless pictures thrown upon a screen, but living realities that move him to action. What consummate folly, then, to say that the brain secretes thought as a mere physical or physiological function, when it is this vital intelligent universal thinking process that builds the brain and perfects its function. A perfect brain, acting in health and harmony, capable of reproducing the world in thought and consciousness would be the perfection of all form, the harmony of all proportion and relations, and the rhythm of all vibrations in nature, verily a sounding-board of nature; and this is the structure that is to be degraded to the level of the liver by modern materialism, and become a mere sewer. Alas! it is often thus degraded by low ideals and perverted use.

But the brain, even when thus perfected, is not the thinker; it is but the agent or instrument of thought. It is a harp of a thousand strings, but without the player it is silent. It can give forth neither discord nor harmony until the thinker sweeps the strings; and yet the harp, the player, and the music—the brain, the thinker, and the thought—are all one, just as we say a musician becomes identified with his music and sings his very soul into it. The physical structure of the brain is under physiological law; it is developed by use, and either strengthened or weakened according as that use is normal or perverted. Fill the brain with alcohol, or render it torpid by opiates or gluttony; let the strings that vibrate and the chords that are struck be habitually only those of lust or passion, selfishness or greed; and let these vibrations only proceed in warring discords from the harp of a thousand strings, and you will build the very structure of the brain into deformity, and its creations will simply be a new Inferno,—every element warring with every other, and the whole world of thought and life will clash with the harmony of nature. In other words, such a brain, such an individual, instead of epitomizing nature, will simply have destroyed itself.

I have thus, I think, pictured mental alienation. Now let us analyze it. The structure and function of the brain certainly enter

into the problem of mental alienation, but they by no means constitute the whole problem. As already noted, we have first the thinking principle. This is universal. Next we have the thinker. Let us call this the personal pronoun "I," or "I am I." Next we have the brain or organ through which thought manifests its functions. The active operation of all these elements in man results in thought and manifests mind. Sensation, perception, will, and desire belong to or are related to the mental operations, and the various forms of mental alienation depend on whether one or another of these faculties is primarily or largely involved.

Will may be considered as the focalized result of the entire energy of the man, and desire is the relation of this energy or will to self-consciousness,—that which gives it color or tendency in one or another direction as related to self. These cannot be left out of account in any mental operation whether of a healthy (normal) or diseased (abnormal) character, for they furnish what we call *motive* to action, and hence determine results.

The mental plane in the life of man is the real field of battle. It is here that are formulated the ideas, impulses, and motives that direct the outward life. It is the thought forms that serve as patterns into which are woven the fabric of life. The mind is the designer; the will the motor power; desire gives color and direction; and so the warp and woof of life in the busy loom of action are formed into patterns on the field of destiny. Healthy action in relation to all these elements tends to secure the best interests of the individual and of society. Unhealthy action consists largely in the attempt to secure his own personal ends at the expense of society, and results in injury to both. Instead of epitomizing nature, man thus creates an artificial and fantastic world of his own, out of harmony with nature and the universal mind. The strain to which such a creation is subjected creates friction and finally destroys itself. Even the brain tissues become diseased; local apoplexy occurs, with complemental anæmia, leading to deranged function, and finally disorganization and death. Even dementia and final idiocy may thus result. In the latter case, the human attributes disappear, the manifestation of mind ceases, and man becomes an animal in human form. He may become a human imbecile, pitiable yet harmless; or a human tiger, destructive and dangerous. This will depend on the conditions of will and desire in relation to self-consciousness, and the trend or direction previously acquired while reason was more or less active.

It may thus be seen that a careful analysis of mind itself and of its healthy manifestation must precede all considerations of mental alienation.

The point I specially emphasize is that the mere function or physiology of the brain is but one element among the many that enter into the problem, and that a distinct idea of the thinker, the real actor or agent, must never for a moment be lost sight of. Add to this idea that of a universal principle on the one hand, and the mechanism and conditions of action on the other, and we have the elements from which may be clearly apprehended both normal and abnormal mental action.

Mental alienation can only be understood through a broad and comprehensive, an exact and logical philosophy of mind; and this the mere physiology and pathology of the brain can never furnish, because beyond the physical basis there is the metaphysical realm, which in a special manner concerns all mental operations. Never till this higher realm is explored, and till order and law are brought out of the chaos now existing, can mental alienation be understood and prevented or cured. I have indicated the points that must be embraced in this philosophy, but not the philosophy itself. That is hardly a subject for a fifteen-minute essay, but rather the study of a lifetime. It is, however, a study that is forcing itself more and more upon the physician's attention, and ere long he will be compelled to give it heed. A true philosophy of mind is an exact and comprehensive synthesis of all mental operations whatsoever, based upon an exact science of the brain and its functions. This is far beyond mere empiricism, and it equally transcends materialism, for it includes a knowledge of the entire nature of man as a spiritual no less than a physical being.

MALPRACTICE IN ACUTE GLAUCOMA.

BY HAROLD WILSON, M.D., DETROIT, MICH.

(Read before the Homœopathic Medical Society of the State of Michigan, Detroit,
May 17, 1892.)

ALTHOUGH the subject of this paper is, in a measure an indictment against the general practitioner, those of you who have had the opportunity of seeing how important is the matter of which it treats, will, I am sure, forgive the charge. Acute glaucoma is not a common disease, but there is hardly any affection of the eyes more

rapid and terrible in its destructive nature. Vision may be totally destroyed in a few hours in some malignant cases, and no disease needs clearer insight or better understanding as to what must be done, and perhaps none shows more often the effects of mismanagement. This is the excuse I offer for taking your attention for a few minutes.

Glaucoma is not a self-limiting disease. Acute attacks will subside eventually under bad treatment, or under no treatment at all. Except under proper treatment, however, they always leave the eye very much damaged, if not altogether ruined, and liable to a renewal of the acute trouble at any time. For this reason it is important to have a clear understanding as to what are the positive symptoms of this disease, and an equally clear understanding as to what is its proper treatment.

The value of diagnosis in the treatment of disease is a much debated question among the members of our school. We may find not a few practitioners who prescribe for diseased conditions irrespective of the diagnosis, and who do not consider it of much value in determining the proper means of cure. Others make the diagnosis the basis of the prescription. Now from an ophthalmic standpoint, not to open the entire question, this much may be stated with confidence: *The proper and intelligent treatment of eye diseases in general, necessitates their accurate and careful diagnosis.* I am aware that this sentiment will not meet with universal approbation. Some of you may consider it not very homœopathic. It is not the province of this paper to discuss it however, except in a very limited way, and for the present, we shall assume it as proven, and shall show how it obtains in cases of acute glaucoma, at least.

Much has already been written about this disease. It has been a favorite topic for society papers for many years. The general practitioner has been told about its ætiology, pathology, symptoms and treatment, many times over. Nevertheless, I question whether he has any but the most hazy notions about it, as a rule. The result of these indefinite notions is, that when he has a case of acute glaucoma to treat it is very apt to result in blindness. A lady, aged 65, came from a small place in the country, a few weeks ago, to consult me in regard to her eyes. Up to four years ago they had never given her any trouble. At that time a violent inflammation came on first in one eye, and later on involving the other. She was treated by her physician from January until June, without much relief. Then changing physicians, the inflammation rapidly subsided, leaving

her totally blind in one eye, and nearly so, in the other. What little vision there was in this eye had gradually grown worse, until when I saw her, there was only the merest trace of light perception remaining. An operation proved, as was expected, of no avail. It was too late to do anything, and she had nothing to expect but absolute blindness for the rest of her days. There is no doubt, that with proper treatment four years ago, during the acute outbreak, this patient might have had useful vision. The trouble was, her physician did not know what was the matter with his patient. He did not rightly diagnosticate his case. Had he done so, the slightest reference to an ophthalmic text-book would have enabled him, in all probability, to have done her some good. Every oculist can report similar cases.

If then, we have made the diagnosis of glaucoma in a given case, what is its proper treatment? In the first place, the overwhelming experience of homœopathic oculists is, that it is not safe to rely on the single remedy, prescribed on the totality of the symptoms. I will not say that such a prescription will never cure a case of acute glaucoma, but think it more than doubtful whether there can be found a single specialist in our school who would so restrict his treatment; at least, unless there were immediate and positive improvement to be noticed. We may say then, with confidence, that in the present state of our knowledge, the "indicated remedy" alone, is not the proper treatment. Something else must be done. In brief, this something else is either the local use of eserine to contract the pupil, or the operation of iridectomy, or both. Other methods or remedies it is not necessary to discuss here. The experience of more than thirty-five years has justified the profession in the dependence placed upon iridectomy, and, until something equally good and reliable can be demonstrated, it will not be set aside. As to the use of the sulphate of eserine, it is, of course, empirical, but abundant clinical experience has shown its value. Any text-book will explain its action and sphere of usefulness. In addition to these two measures, it is the duty of the homœopathic physician to treat his patient according to the therapeutics of his school. The indicated remedy must not be forgotten, as it is capable of rendering much help, but, if we must forget anything, let us forget this rather than either of the measures above referred to. But if an iridectomy has to be made, how can it be accomplished in the absence of a competent specialist? It is not an easy operation, and yet, if a specialist cannot be summoned, or if the patient cannot be sent to one, the gen-

DIAGNOSTIC TABLE OF ACUTE INFLAMMATIONS OF THE EYE.

NOTE.—This table is more or less imperfect, as the symptoms of the various ocular inflammations often overlap. It is intended to assist in their diagnosis, but not to take the place of the fuller descriptions of the text-books.

Eyeball red and inflamed.	Lids markedly swollen. Pains localized and not very intense.	Discharge from eye watery, with photophobia. Pain superfic'l and relieved temporarily by cocaine. Lids sometim's but little swollen.	Cornea vascular or opaque.	Vascular Keratitis.		
			Ulcers on cornea.	Ulcerative Keratitis.		
			Abscess in cornea.	Suppurative Keratitis.		
			Cornea clear; œdema of the conjunctiva; no discharge.	Orbital Cellulitis.		
			Conjunctiva smooth or velvety.	Catarrhal Conjunctivitis.		
	Lids not at all or but little swollen.	Discharge from eye mucous or mucopurulent. Very little pain or photophobia.	Conjunctiva rough and granular.	Trachoma.		
			Symptoms intense; conjunctiva and lids greatly swollen.	Purulent Conjunctivitis.		
			Conjunctiva smooth or velvety.	Catarrhal Conjunctivitis.		
			Impairment of vision very rapid and extensive; pupil regular; usually dilated; tension of eyeball increased; ciliary region not specially sensitive; great pain always present.	Glaucoma.		
	Discharge from eye watery or none at all. Pain very marked, extending to surrounding portions of head and face.	Vision greatly impaired.	Impairment of vision slow; pupil fixed and irregular; tension of eyeball not (ordinarily) increased; exquisite tenderness of ciliary region; sometimes little or no pain.	Iridochoroiditis.		
		Vision moderately impair'd (or when greatly impaired, obstructions may be seen in pupillary area).	Iris discolored; pupil contracted, sluggish or immobile; fine red streaks radiating from cornea, in sclera; ciliary congestion.	Iritis.		

eral practitioner must do the best he can. Fortunately, in these acute cases an imperfect operation will often suffice, and any intelligent physician may, by a little study and practice upon pigs' eyes, fit himself for such an emergency. A skilled operator should be secured, if possible, and without delay; but, if this cannot be done, the emergency must be met by the physician in charge himself.

If, then, the treatment of acute glaucoma is thus clearly marked, it is evident that its diagnosis is a matter of the utmost importance. It is not so necessary to operate upon other inflammatory affections of the eye; in fact, it is only in special cases that an iridectomy is even desirable. The chief distinctive signs of acute glaucoma are increased hardness or tension of the eyeball, rapid and great diminution of the vision, and a dilated pupil. In order to make the diagnosis more easy for the general practitioner, and, at the same time, to facilitate the diagnosis of acute inflammations of the eye in general, I have prepared the foregoing table, by the aid of which it will be found easy to make not only the diagnosis of acute glaucoma, but also of those acute inflammatory affections commonly met with. The mode of using it will be seen at a glance, and it needs no further description. For convenience, I have had this table printed and distributed to the members of this society, and I trust that it may be found worthy of study and preservation:

To summarize:

1. Acute glaucoma does not tend to spontaneous recovery.
2. If not properly treated it terminates in blindness.
3. The proper treatment consists in the local use of eserine; the operation of iridectomy, and the homœopathically-indicated remedy.
4. Its accurate diagnosis is indispensable.

THE PRACTICAL RELATIONS OF HOMŒOPATHISTS TO THE GERM-THEORY.

BY GEO. B. PECK, M.D., PROVIDENCE, R. I.

(Read before the American Institute of Homœopathy, Washington, D. C., June 15, 1892.)

WHAT is a Homœopathist? "One who is versed in or who practices Homœopathy." And what is Homœopathy? "The medical treatment of diseased conditions of the body by the administration of drugs which are capable of exciting in healthy persons symptoms

closely resembling the morbid conditions treated." (To this definition the *Century Dictionary* properly adds the remark: "In practice Homœopathy is associated with the system of administering drugs in very small, often in infinitesimal doses.") Upon what is it based? Upon a law of Nature recognized and enunciated in the very childhood of the human race now tersely rendered *similia similibus curantur*. But what is a natural law? "A proposition which expresses the constant or regular order of certain phenomena or the constant mode of action of a force; a general formula or rule to which all things, or all things or phenomena within the limits of a certain class or group conform, precisely and without exertion; a rule to which events really tend to conform." And what is it to cure? "To restore to health or to a sound state; to remove or to put an end to by remedial means." It follows then that he who would restore a sufferer to health by the administration of drugs *must* administer them in accordance with the formula, *similia similibus curantur*, and that prescribing thus, whatever else he may or may not do, however else he may be designated by himself or by others, he demonstrates himself to be strictly a Homœopathist.

What now is the scope of the Germ-Theory? A theory is a "perception or consideration of the relation of the parts of an ideal construction which is supposed to render completely or in some measure intelligible a fact or thing which it resembles or to which it is analogous; also the ideal construction itself." Hence the Germ-Theory is an "ideal construction" of the relation certain micro-organisms bear to certain pathological conditions which "ideal construction" "is supposed to render them (the said conditions) completely or in some measure intelligible;" in other words, it is the proclamation that certain diseases are fermentative processes. Upon this hypothesis a system for the prevention, not to say cure, of fleshly ills has been erected. Whether or not the construction conforms to an actuality, whether or not one or fifteen or fifty-nine of the sixty odd, yea ninety odd, indented species of schizomycetes are proven to be the cause of one or more of the diseases (so-called) that afflict our race is a matter of complete indifference. In either case it is the duty of Homœopathists as physicians candidly to consider its claims, for Hahnemann was of the foremost hygienists, and nothing pertaining to the best interests of man was foreign to him. Faithfully has this responsibility been met. Carefully have the relations of the Germ-Theory to the Law of Cure been studied practically as well as theoretically. Of the adherents of the New School in every

thousand 626 unhesitatingly affirm that asepsis and antiseptis are alike compatible with the system of medication detailed in Hahnemann's *Organon*; 53 admit the harmony of asepsis; 186 declare the systems at variance while only 13 admit they have formed no opinion.

Homœopathists can have no practical relations with the Germ Theory as physicians because the Law of Cure is supreme in non-surgical disorders. Neither as surgeons for, although there is a homœopathic surgery with its appropriate specialties rendering daily possible the performance of feats utterly unattainable by our friends the Regulars, surgery *per se* presupposes drug incurability. Only as obstetricians occupying a well marked field between, or rather including portions of, these rival and yet supplemental domains of Æsculapian art can Homœopathists be said to enter into actual relations with the modern Diana of the medical world. This occurs because parturition, although a physiological, is rarely a normal process and oftentimes a surgical. The American Institute of Homœopathy, by reason of its age, stature and good works, justly claims the prerogative of speaking as the representative of that sect everywhere spoken against. Her children are abundantly competent to testify on all matters regarding the school. Listen then to their experience after a moment's pause to learn the exact signification of terms they will employ.

Asepsis is "absence of" and aseptic "free from the living germs of disease, putrefaction or fermentation." Antiseptis is "the more or less complete exclusion of living micro-organisms from those bodies or substances in which they produce disease, putrefaction or fermentation. Such organisms may be destroyed as by heat or germicides or excluded by coverings or cleanliness or their activity and multiplication may be restricted by the application of antiseptic substances or of cold." Antiseptic signifies "pertaining to antiseptis; inimical to the growth and activity of the micro-organisms of disease, putrefaction or fermentation. Anything which destroys the micro-organisms of disease, putrefaction or fermentation or which restricts their growth and multiplication." Now although by derivation and by established good usage the idea of passivity is saliently conspicuous in the first two words and of activity in the last two, so loosely are these terms popularly employed and so often is an object aseptized by antisepticizing it that in this investigation it is necessary more sharply to distinguish between them. Practically then antiseptis signifies the application of germicides to the identical

places wherein they are expected to perform their appropriate function; asepsis signifies the exclusion of germs from places wherein they are likely to work evil. For good and sufficient reasons which may or may not be apparent "to all to whom these presents shall come," a sub-class of aseptic instrumentalities has been set aside and the title of Ordinary Cleanliness arbitrarily assigned. The treatment of sepsis, therefore, will be reported under three heads: ordinary cleanliness or a judicious use of hot water externally with or without soap; asepsis or the application of germicides to any part of the person of the physician or nurse or patient (if not covered by mucous membrane) also to instruments or to any material employed at any stage of the confinement, with the use of hot water douches unrequired by hæmorrhage; antiseptis or the application of germicides to the genito-urinary mucous tract in any form at any time during the entire confinement. Antiseptis implies, moreover, ordinarily the employment of aseptic methods conjointly.

Of every thousand reputable homœopathic practitioners 670 are accustomed to observe ordinary cleanliness only in their obstetric practice. If to these be added those who use hot water douches alone of all aseptic measures the number will be increased to 723. In the former group 444 never resort to asepsis and 333 never to antiseptis. Ninety-eight have tried antiseptis and found it to be unnecessary or harmful, one remarking that during "an experience of over 700 cases without aseptic or antiseptic methods I have been absolutely free from serious sequelæ of any kind, while with the first 300 cases when practicing under the allopathic system and all its tomfoolery of asepsis and antiseptis, I was in hot water all the time," and another, that "every woman douched exhibited more or less indications of fever." A comparison of their own results with that of those practicing *secundum artem* has satisfied 244 that germicides are unessential (although twenty-three occasionally employ them). More than one-fourth of this class have practiced from seventeen to forty-three years respectively, without a death or particular trouble from septic causes. One gentleman reported but one death in forty years due to puerperal conditions and another one in thirty-three years. A third has met a single case of puerperal fever in twenty-four years, while a fourth has had all his patients do well save one in the past fifteen years. A fifth, who has been at work forty years cannot see but what his success is equal to that of his neighbors; a surgeon in the enjoyment of a large obstetric consultation practice, in addition to ample private work of that

nature as well as in his specialty, has experienced no trouble from the omission of germicides in this department, while a physician of eighteen years' standing has witnessed no delay in the recovery of his patients, although cases of scarlatina and erysipelas were attended synchronously in the same room. These incidental gleanings are presented chiefly because eminent Regular authority justly makes honorable mention of a practitioner who attended, before antisepsis was dreamed of, four thousand accouchements without encountering a case of puerperal fever, and another who safely confined a woman in the same room with an erysipelas patient.

"That which other folks can do,
Why with patience may not you?"

It remains to be added that of the 670 who ordinarily employ simple cleanliness 200 state that occasionally they resort to asepsis and 320 occasionally to antisepsis. Nearly all the former are included in the latter grouping.

Asepsis in its strict signification is the customary usage of 161 practitioners in every thousand, but omitting those whose asepsis consists exclusively of hot water douching, there are but 108. Of the entire number, eighteen have satisfied themselves by experiment that this is the best way and an equal number have been educated to the belief. Sixty-seven confess they occasionally omit it, but eighty affirm they never do. Thirteen occasionally employ antisepsis, eighteen declare they do not.

The devotees of antiseptic art number 160, but fifty-eight of them lapse into ordinary cleanliness now and then, although ninety-eight are never guilty of such indiscretion. Twenty-seven use asepsis sometimes, but sixty-seven are true to their principles under all circumstances. Eighty have enlisted under this banner because they were thus instructed, forty after testing one or both of the other services.

Summary.—While more than four-fifths of the Homœopathic School find no antagonism between its principles and the Germ-Theory so-called, well nigh one-third of its members find no use whatsoever for the special methods implied by a recognition of the truth of that theory, satisfied by observation and experience that they are useless, not to say harmful, and nine-twentieths more employ them but rarely. One-sixth *Regularly* introduce germicides within the parturient canal, while one-tenth are content to apply

them to the person of the patient, or of the attendants, or to the instruments.

These facts conclusively prove the Homœopathic School is a *free school*; that any and every subject presented to its members is considered on its own merits and judgment is rendered in accordance therewith, unbiased by any prejudice ignorantly believed to trammel their action. The claims of Hahnemann and of Koch, of Pasteur and of Brown-Séquard are scrutinized by them with strict impartiality, and if to either recognition is accorded as chief and leader, it is simply because he first placed within the grasp and control of man certain natural forces which, intelligently guided, effect results elsewhere unattained. When another renders equal service to his race to him will equal homage be paid.

These facts furthermore strikingly indicate the importance to the New School of its possession of, and its appreciation of, the Law of Cure. No more vigorous onslaught has been made, possibly can be made, against cherished medical opinions than that of the Germ-Theory. Having demonstrated its postulates in microscopical and physiological laboratories, it demanded immediate acquiescence in its plausible though unwarranted conclusions, as well of the physician as of the surgeon. With the force and impetuosity of a volcanic tidal wave, o'ersweeping for the time all other "currents and counter-currents of medical science," it dashed against the rock on which is encamped the battalions of Homœopathy. Their tents are securely pitched, however (that is to say most of them), far above the angry waves. Two-fifths of the host were unreached even by the driven spray, two-fifths more were but slightly sprinkled, while only one-twelfth were well drenched,—although to these should be added another twelfth who landed on the cliff toward its seaward side when the billows were rolling the highest. In other words, despite ocular proofs and assurances of brilliant successes and threats of criminal suits for neglect, more than two-fifths of our practitioners still hesitate to inject irritating, not to say poisonous, solutions into an unclosed, bruised, perhaps lacerated, osmotic canal; another two-fifths and more employ them as rarely and as guardedly as they do the scalpel, the curette and the cranioclast, while a twelfth only were induced to engage in indiscriminate, exterminating warfare against a possibly present foe, and another twelfth have been educated up to such an eminently *rational* and *scientific* procedure by—what authority?

It is well to note in this connection that the science of bacteriology

has attained such perfection, has so clearly outlined the relation of disease-producing germs to living human tissue, as plainly to indicate if not absolutely to demonstrate the superior wisdom of those who have steadily resisted the extravagant demands of the early champions of the Germ-Theory. The ingestion of germicides for the destruction of noxious bacteria is already an antiquated notion for more than two years since it was established beyond a peradventure "that fresh blood serum possesses a most marked germicidal power," and "that a similar germicidal power resides in fresh human non-inflammatory transudations." Even the microphages and macrophages, credited in the current volume of the *International Medical Annual* with the highest functions, have been shown to be "not essential to the essence of immunity," and their work to be a "secondary process, the bacteria being taken up by the leucocytes only after having been rendered inert through the normal germicidal activity of the serum of the blood and other fluids of the body." The bulwark of our health and of our lives appears at date (April 13, 1892) to be a "protecting proteid eliminated by the cells of the tissues not of necessity antagonistic to the life of the (invading) organisms," but "an antidote to their poison." "These proteid bodies (are) normally present in their integral cells," and "when infection occurs (it is) either by the excess of vigor of the bacterial products over the antidotal or protective proteids eliminated by the tissues or to some cause that has interfered with the normal activity and production of these bodies by the tissues." Only one of the countless vindications of the principles of Homœopathic drug selection and of Homœopathic dosage Regularly discoverable in Regular literature!

But more particularly a third savant of unquestioned and unquestionable Regular authority notifies his brethren some time since that "among the influences which have been found favorable to the growth in wounds of bacteria which otherwise might be disposed of by the tissues and animal fluids without harm are * * * the necrosis and degeneration of tissue caused by the contact of strong chemical disinfectants with the wounded tissues. * * * If it were within (their) power to keep bacteria out of wounds or to destroy them without damage to the tissues after they enter the conditions just mentioned could not by themselves alone cause infection, but this power (they do) not at present possess, as is demonstrated by the bacteriological examination of wounds treated aseptically or antiseptically. Hence it behooves (them) to learn all (they) can con-

cerning those conditions which favor and those which are hostile to the development of bacteria in wounds and to endeavor to retain and produce the hostile and to remove the favorable conditions for the growth of bacteria." In the same paragraph he warned them that while "the indication is no less urgent than ever before to keep bacteria out of wounds in every way possible," "it seems plain that (their) efforts have been directed too exclusively toward this indication and toward the attempted destruction of bacteria which may have accidentally entered the wound and not enough toward preserving as far as possible the germicidal powers of the tissues and fluids." He assured them that "it is becoming every day clearer that the most valuable friend (they) have in their efforts to secure aseptic healing of * wounds is the capacity of the fluids and cells of the animal body to overcome invading micro-organisms." I may as well confess that I have been somewhat of a sinner in that I have at times prescribed post-partum potassium permanganate douches simply because that sort of thing is more or less fashionable, but neither I nor any other physician "to whom these presents shall come" can make any defense whatsoever in the event disaster should follow routine indulgence in such practices for the act will be committed with full knowledge that however distinguished may be the person who shall be cited as an endorser in this particular at least he can be considered as but a mummified dispenser of fossilized lore!

Two lessons from these incontrovertible facts must suffice. First, run not hither nor thither in feverish, unseemly haste at every cry Here is Truth or there is Truth, for lo! Truth with you abideth ever. Though but a single truth its ramifications are so broad, its relations so intimate with everything in the field of our life work that it should be to us a veritable touchstone readily applicable as it is to each new statement of fact and of theory, promptly determinant of its absolute value. Is it in accord with the law? Grasp it firmly, hold it fast! Is it at variance? Regard it not, however attractive in appearance it is but an Apple of Sodom! Nature *never* contradicts herself! Is it unrelated? Let those who have no higher mission than blind experimentation make the first trials; it matters little upon *what* scientific (?) grounds their victims are slaughtered! Pathology must be rewritten, and again and yet again to accord with the progressive revelations of the microscope and of the retort. Homœopathy is unchangeable for it rests upon a double set of phenomena as persistent as the established constitution of terrestrial creation. To eschew it because we do not understand the

rationale of their relation is as sensible as the rejection of the compass because we cannot explain magnetism, of the telegraph and the trolley because we know not the nature of electricity, of all chemical processes because ignorant of the essence of chemism, of food itself because we comprehend not the mechanism of assimilation.

Second, study *materia medica* much, popular theories little. "The first and *sole* duty of the physician is to restore health to the sick" (Hahnemann). Intimate acquaintance with the latest notions of disease-action is worthless to cure for they change with each year if not with each month, and nature unfortunately does not modify her acts to conform to man's opinions. Little recks the anxious sufferer how apt we are as chemists or microscopists or physiologists or sanitarians if we cannot eradicate the malady that destroys his comfort and threatens his life. While not unmindful of minor matters remember *our* best hours and strongest endeavors are but the just due of that science which is the foundation of our strength, the fountain of our existence.

IODINE IN MIDDLE-EAR DISEASE, LOCALLY IN VAPOR, INTERNALLY AS CONSTITUTIONAL TREATMENT.

BY L. W. JORDAN, M.D., INDIANAPOLIS, IND.

(Read before the Indiana Institute of Homœopathy, May, 1892.)

THERE is probably no one sense that contributes as much to the intellectual happiness of men as that of hearing.

The greater number of deaf people sustain their loss of hearing from chronic middle-ear disease. Dry catarrh, chronic non-suppurative inflammation, adhesive catarrh, etc., are the names applied. The classification of middle-ear diseases is conventional rather than scientific, for acute and chronic suppurative inflammation, mucoserous catarrh, acute non-suppurative inflammation are pathologically and ætiologically connected with the former. But these disorders affect the hearing only temporarily or are generally non-progressive, and have for years been more or less curable.

The general apathy noticed among aural surgeons in dealing with the dry catarrh class of disease is due to the belief that this most common disorder is incurable.

The special pathology in the order usually considers, first and foremost, occlusion of the Eustachian tube, caused on the one hand by

naso-pharyngeal disorders and producing on the other an imperfect renewal of the atmospheric air in the cavity of the middle ear. The small tympanic cavity, lined by the most delicate ciliated epithelium, which also covers the ossicles and two small muscles, requires the stimulus of pure air to maintain its normal secretion and action of the cilia, which carry off through the tube the detritus material.

From this stoppage, then, follows accumulations, abnormal action, hypertrophic inflammation, periostitis, stiffening or solidification of the joints of the bones that conduct the sound through the cavity, relaxation or contraction of the muscles, whose duty it is to keep the tension of the two drums ready for receiving sound-waves, and even the filling up of the cavity with adenoid tissue.

Rarefaction of the air penned in, by its absorption, causes undue contraction of the ear-drums (including the oval window as one). The disease often then extends through the fenestral structures to the internal ear, by continuity of similar structures, and thus injures the end organs of the auditory nerve and its immediate appendages. The last hope of recovery is thus lost.

Disorders of the nose and throat, stoppage of the Eustachian tube by extension of inflammation over contiguous and similar membranes, stoppage of the normal action of the tube, which in turn sets up destructive inflammation of the middle ear, and then pathological changes in the labyrinth is the short history of the disorder.

Treatment.—It is pretty generally conceded the past few years, that proper treatment of the nose and throat will in many cases avert the disease and in some cure it, and in a fewer number improve or stay the progress of the affection. In a limited number of cases the artificial irrigation of the tympanum, by use of Politzer's apparatus or the Eustachian catheter, for forcing atmospheric air into it, has relieved more or less.

A little over a year ago, while attending a New York ear clinic, I noticed one of the assistants using air impregnated with the vapor of iodine and camphor. The doctor did not seem to have much confidence in it, for he remarked, while treating a patient affected with a proliferating inflammation of the middle ear shortly afterwards: "Gentlemen, you might as well learn, first as last, that this kind of a case is incurable. I believe there has never been a case cured." He further advised the use of infiltration of the middle ear by catheterization five or six times, and if no improvement appear, to discontinue further efforts as being useless. Dr. Thomas Barr, in his excellent work, recommends one month's trial.

The use of the iodine in vapor form struck me, as it reminded me at once of the strong indications for its use as laid down in our *materia medica*. The most prominent set of symptoms of iodine in its gross and immediate action is the well-known iodism. This is a nasal catarrh pure and simple. Then, its power over hypertrophy is well attested. More carefully followed come the symptoms of deafness, noises in the ears, dizziness, and many other occasional symptoms, common to the disease and drug pathogenesis. I resolved to make a thorough trial of it, which I now am doing with pleasant results. Dr. Roosa refers its use to the suggestion of Dr. F. H. Rankin, of Newport.

The unpleasant and often destructive effect of liquids applied to the middle ear is generally acceded. No such opinion as to the use of medicine *diluted with atmospheric air* prevails. I believed it to be a *safe* method, as the *evanescent effect* would certainly suggest to any one, while liquids injected into the tympanum through a stenosed tube are intended to remain there and set up mischief, as the delicate membrane does not normally receive fluid. But as air is its normal bath, to apply medicine by that agent, and one that would promise so much as iodine, seemed to be a happy idea.

The first case that applied was a middle-aged, intelligent lady of high standing in this city, referred to me by Dr. W. B. Clark. Both ears were affected. With the poorest ear she could hear neither voice nor watch, and showed evidence of the internal ear having been encroached upon by the use of the fork placed on the head. With her best ear she could hear the watch when pressed against the ear, and could repeat two words out of three at a distance of seven feet, ordinary voice being used, and the words being those used in counting one to a hundred. She was not apprised of the nature of words before, so that in subsequent examinations there could be no false appearance of improvement from the use of familiar words or anticipated words. The drums were opaque and sunken. The Eustachian tubes impervious by Politzer's method, and nearly so by catheter. The ordinary subjective symptom of noises in the ears was complained of severely. There were no nose symptoms save frequent sneezing and acute stoppage of the nose, which passed away quickly. She had gone through the ordinary treatment, however, for hypertrophic nasal catarrh, the anterior part being subjected to electro-cautery, the anterior third of the nose being quite open. No examination of the post-nares could be made for several months on account of peculiarities of the patient.

No constant secretion from the nose anterior, or posterior, was found. The case was pronounced to be one of the most incurable form of chronic middle ear disease by those whom she had formerly counselled and in the opinion I concurred. Thus expecting soon to have what hearing she possessed in her right ear taken from her, as it was going perceptibly every quarter, she was willing to make a desperate effort. Almost daily treatment was given for two months without signs of improvement. The treatment was iodine internally, and imperfect irrigation of the middle ear with iodo-camphor vapor diluted with atmospheric air, the nose being cleansed daily with an alkaline solution. The tubes were hard to enter and seemed almost impervious to the vapor. The next two weeks showed improvement. In six months the roaring in the ears was gone and there was marked improvement in hearing. After one year of at least tri-weekly treatments improvement ceased. At that time she could hear the voice with the poorest ear 8 to 12 inches, and a tuning-fork ten to fifteen seconds that should be heard in front of the ear sixty to seventy seconds. Bone conduction of sound decreased. With the best ear, she then could hear the voice 33 feet that should normally be heard about 40 feet; the watch 10 to 15 inches that should be heard 36 inches; a middle C tuning fork sixty seconds, that should be heard sixty to seventy; a C fork one octave higher but twenty-five seconds that should be heard forty-five. Bone conduction of sound reduced to normal approximately. She had no trouble to hear public speakers, nor ordinary conversation. She remains the same now, having gone three months without treatment, the Eustachian tubes being normally open, interchanging the air of the tympanum at each act of swallowing, which will insure, I believe, future immunity.

After nine months from the time of taking the case I succeeded in examining the naso-pharynx thoroughly. Three of the turbinated bones on one side and two on the other, posteriorly were hypertrophic, so as to touch each other continually, and impinged on the floor of the nares and septum, thus stopping the action of the cilia and acting as a reservoir for the poisonous particles caught from the inspired atmosphere. The middle third of the nares could not be seen by any method. From these hypertrophies and consequent abnormal function, want of normal function rather, came the sneezing, the acute occlusions of the nose, and I believe the middle ear disease. These hypertrophies were treated by deep punctures with a small galvano-cautery, which destroyed very little of the tis-

sue, but which caused speedy atrophy, and return to the normal size. This procedure is better than the ordinary cautery or amputation, as it leaves no scar tissue, merely a puncture to heal up, and preserves the normal mucous elements. I believe the patient is well of the middle ear disorder.

I have given this case rather in detail and analytically, because it has been my most difficult case, requiring the longest treatment, offering at first the poorest results, and because one case well studied offers more information than hundreds imperfectly presented.

During this time twenty-one patients have been under treatment, not including those taken too recently to pass an opinion on. Of this number, two were unimproved. One came to me from the deaf and dumb asylum; hearing distance of the voice was doubled however, but stopped there. The other referred by Dr. Wehrmann of this city was a patient advanced in years and had just recently sustained the results of an aneurism or embolism of the brain, causing tinnitus, almost total deafness in one ear and dizziness, with contraction of the pupil on the same side of the head. He is still under treatment for this condition.

The previous middle ear disorder had received but little attention. It now shows no improvement.

Five cases have been cured. One referred by Dr. Helming, of Indianapolis. This was a remarkable case from total occlusion of the post nares from adenoid tissue in the naso-pharynx, and post-nasal hypertrophies—a mouth breather, with pigeon breast and stoop shoulders, pale and anæmic. Her general health is greatly improved also.

Two cases made perfect recoveries, by both air and bone conduction of sound, both becoming normal. Nine cases are very much improved and still under treatment. One, an elderly lady, referred by Dr. O. S. Runnels, could only hear the voice when the lips pressed her ear, and now hears 10 feet. One lady 60 years of age, disease of three years' standing, hearing distance improved from 3 feet to 25 in ten of fifteen treatments. In a boy, aged 7, the hearing changed from four feet to normal (practically), in a half dozen treatments.

Without giving details further, it might be well to mark the conclusions one would make by a full analysis of these few cases, remembering that they are recent and most of them still under treatment. Youth and short duration in the aged are favorable conditions. Naso-pharyngeal catarrhs antedate the ear symptoms, and suggest a more careful study of such disorders as a branch of otology.

Young patients are cured in one-tenth the time that elderly and more chronic patients require. Galvano-cautery puncture of hypertrophies, not cartilaginous or bony, causes speedy atrophy, the softer the tumor the faster the atrophy. In one case, nine punctures were made in two successive days with but little inconvenience following with best results. Cases of hereditary deafness show likewise evidences of hereditary nasal and pharyngeal troubles. The decrease in the bone conduction of sound as improvement of hearing appears is conclusive evidence of the reduction of the middle ear hypertrophies.

PRACTICAL EMPIRICISM.

BY SAMUEL N. WATSON, M.D., IOWA CITY, IOWA.

As scientific physicians the homœopathists of to-day claim to stand before the public as exponents, both in theory and in practice, of what they are proud to denominate a "Law of Cure." Their very *ratio essendi* lies in this one fact, according to their own statements, that they depend in their efforts for the healing of the sick, not upon an arbitrary system built up from tradition and founded upon guess-work, nor yet upon a system equally faulty in its origin and based upon the observed effects of drugs upon the sick, but upon a law, by which law the symptoms of drug disease and of idiopathic disease have a definite and well-known relation. This is the very soul of the homœopathic body. It is for this that the Fathers fought. It is by this they won. It is in this that the homœopathic school consists as a distinct entity. If the follower of Hahnemann realizes at all the strength of his position at this present time, he must know that it is the rigid and unyielding claims of his medical progenitors to the possession of a law, and their constant denunciation of the cruelty of empiricism that have won for him the recognition in the world of medical science which is his.

That cannot claim to be a science in this enlightened age which neither brings itself nor makes effort to bring itself within the range of some law of cause and effect, which law shall embrace and dominate all phenomena covered by its premises and conclusions. That the existence of at least a law in therapeutics is recognized either openly or tacitly by all classes of practitioners needs little demonstration. This to the homœopath is his nominal watchword, even

though he may often practically disregard it; while the old-school practitioner, by the use of the now largely advertised pharmaceutical preparations of pilules of $\frac{1}{100}$ grain ipecac for nausea, $\frac{1}{100}$ grain tartar emetic for capillary bronchitis, $\frac{1}{100}$ grain belladonna for cerebral congestion, $\frac{1}{100}$ grain phosphate for fatty degeneration (as many of them do daily) acknowledges tacitly the law whose effects he is glad to make use of.

Yet, with the full possession of this impregnable position, to which the medical world is slowly (should I not rather say *rapidly*?) coming round, with our own unfailing conviction of the scientific value of the "Law of Cure," at a time when the scientific world is making ready slowly to grant us that position as scientific men and physicians that we have ever so unyieldingly claimed, it seems impossible for many homœopaths to keep themselves clear of what is nothing more nor less than a *practical empiricism*.

Dr. J. P. Dake, in his most interesting autobiography in the June HAHNEMANNIAN has sounded a note of warning that is timely when he says (p. 411) with regard to his own medical writings: "I have seldom ventured to display cases and prescriptions for the very reason that prevented Hahnemann's doing so, namely, the faith one should have in the homœopathic law applied to a pure pathogenesis;" and when he denominates the records "of clinical experience, a source fruitful of all manner of empiricism and uncertainty."

It is just this sort of practical empiricism that is showing its disreputable face almost constantly in homœopathic speech and writing; and it is time that some one called it by its true name. It is to be seen in medical societies, both local and general, and in the columns of many of the journals of our art. The papers read at these periodical gatherings of physicians consist in very large measure of simply a detailed account of cases, common or exceptional, of various diseases, and the remedies exhibited in their treatment, with the most remarkable success in the majority of instances, while the pages of the ordinary medical journal of our school are filled to repletion with "Some Clinical Cases," "Recent Experience with La——," etc., *ad libitum*. (We are proud to say that the few of our journals which we can call "best" are not addicted to this practice to any extent.) The recently published proceedings of a large homœopathic society consist to the proportion of over one-half of simple clinical records, and the pages of a medical journal at hand show fully as large a proportion of the articles in it that lay any claim to being original to be of the same character, namely, the cases of a

given physician and the remedies he thought fit to use for their amelioration. Now, while clinical records have their undoubted uses, this sort of "clinical experience meeting," in which we are indulged to so large an extent just now, is both useless and harmful. It is useless simply because these records are not worth the space and the time they take up; it is harmful because this sort of *cacæthes loquendi* is very likely to be the external symptom of a most dangerous cachexia, which is becoming established in our body corporate.

To the dominant school of medicine, dependent entirely upon knowledge gained from the observation of drug-effects upon the sick, this sort of peripatetic clinic is all important. It forms the staple of their stock in trade. Their successes and equally their failures arise from the fact that their whole therapeutics consist in deductions from an assumed principle that the remedy or remedies which, exhibited in a given case of disease, ameliorate it, will prove equally efficacious if administered to another case having a general similarity in pathological features. Their advance in therapeutics is the result of the gleaning of successes from multitudes of just such experiments arbitrarily made upon the sick. This is just precisely what we condemn unhesitatingly as crude empiricism. To them the record of these drug-experiments upon the sick is of great value. We claim that, for us, basing our therapy upon law, and not experiment upon the sick (except in so far as that experience confirms the law), these records are of little, and often of no value. The fact that Dr. A. B. C. has had a case which he called enteritis, and which yielded promptly to the exhibition of bell., followed afterward by mere. corr., has no therapeutic information to give me when I diagnose a case a short time after as enteritis. Enteritis is merely a name in the Text-book on Practice given to a certain set of pathological lesions, externally indicated by a large group of symptoms, any or all of which may or may not be present; and it may require for its successful treatment remedies as many and as different as are the possible symptoms or groups of symptoms. The therapeutic treatment of a given case of enteritis, or of any other disease, is a safe guide for the treatment of any other disease simply diagnosed. By our fundamental principles, we prescribe not for names in a catalogue—not for pathological conditions as such—but for the symptoms of the individual case, whenever and however they present themselves, denominate them resultants of whatsoever pathological conditions we will. To the individual physician, as Dr. Dake well says, his own clinical experience is by no means valueless, inasmuch

as it both renders more concrete his idea of disease, and also familiarizes him by many comparisons with the characteristics and relative values of his remedies. But to the educated and trained Homœopath this flood tide of promiscuous clinical details under which real learning is being overwhelmed is comparatively useless; to the medical profession at large it smacks strongly of a tendency to that very empiricism which we deery; while to the rising generation of physicians it is positively harmful, leading them to neglect of the study of *Materia Medica*, to neglect the individualizing of their cases, and hence to mere routine prescribing; all of which the great Father of the School truly characterized as little short of criminal.

The field of medical knowledge, as we have received the same, is surely wide enough, and the ability of our practitioners certainly would be competent to give us both in society and journal papers which evince real study and thought, in the place of this wasteful flood of petty "case-peddling," which is at once valueless in itself, and also productive of harm to what should be of the highest worth to us, our reputation as scholars of scientific standing. In theory, we denominate it empiricism to take the effects of drugs upon the sick as a basis for therapeutics. Is it not time we showed in our literature that we adhere to our theory in our practice?

Nothing can be more true, and we need often to be reminded of it, that only that medical logic is safe to follow which has knowledge of the Law as one premise, and a pure pathogenesis as the other. And it is surely a corollary of this axiom, that, an accurate knowledge of drug-effects on the healthy human organism, and a faithful comparison of them by ourselves with the symptoms of each individual case presented for treatment is of infinitely greater value than all the records of clinical experience that were ever written.

Lest this should be taken for mere sentiment or captious criticism, it may be well to refer, in conclusion, to a most forcible argument presented by a fact already mentioned, viz.: the fact that the physicians of the Old School are already using freely the remedies which by discovery and use are our chief possession. The Old School journals show advertisements of one of the largest drug-firms offering a large variety of pilules containing drugs in dynamic doses which are recommended for just those diseases in which the Homœopathic Law shows them to be curative in such doses. Undoubtedly they have a perfect right to them. But, we know that on the antipathic principle of therapeutics there is no possible indication for a powerful emetic like ipecac in a case of nausea; and, we also know that

the Law aforesaid alone can rationally explain its use. But the Allopath, by virtue of his general principle of clinical experimentation, makes use of whatever has been found clinically to be of value; and hence the adoption of our remedies and posology.

But what, then, is the outlook when that process shall have been carried to its fullest extent? With the wholesale adoption of our therapeutics and posology by "our friends, the enemy," where do we come in in the contest?

Our strength lies just where it has always been, in the knowledge of the law and its application, as opposed to clinical experimentation. Our strength is under our feet, in the ground on which the fathers of homœopathy stood. The standard which will lead us to victory bears the same legend as that under which they fought,—*similia*,—law, scientific deduction, as against empiricism. It only needs that a new epidemic of a hitherto unknown disease should break out, like that cholera which devastated Europe in the days of Hahnemann, and which he met and conquered single-handed by the knowledge of the law, to demonstrate the difference between scientific medicine and guess-work. Our one, distinctive claim,—a claim, too, that is rapidly winning its own credence,—is, that of having a law back of our therapeutics as a scientific basis for our prescribing. We have no need for clinical experimentation if we know the first principles of our science, for our therapeutics is a *science*, and not an art merely. It is by this very fact that homœopathy has won, and will ever win, due recognition among thinking men. It is by this that she will stand secure in any future contest for place or name, and anything which looks like a willing abandonment of this impregnable fortress for one less secure is to be looked upon with apprehension and concern.

All of which furnishes us a still further reason why we ought carefully to consider whether we are not paying far too much heed in all our public utterances to the details of clinical experience, interesting enough though they often may be, but utterly valueless compared with those fundamental scientific attainments which should be the first concern of the homœopath who would be a master in his own field, an *accurate pathology* and a *pure pathogenesis*.

SODIUM BISULPHITE is reported to produce excellent results in *tonsillitis* and *coryza*. Teaspoonful doses of a saturated solution are given every hour or two for twenty-four hours, or longer if necessary, the disease being usually controlled in twenty-four hours.

EDITORIAL.

PROFESSIONAL RESPONSIBILITY.

BY far the greater number of medical men fail to appreciate all the responsibilities resting upon them. It is true that all recognize their importance in dealing with the sick, but it is in their dealings with their professional brethren and with fellow-beings in health that they are found wanting. This failure to appreciate the responsible position they hold in the community is brought about by two factors: one, the natural modesty and good nature inherent to medical men, and the other thoughtlessness of all other matters than those pertaining directly to their profession. The evil or vice of which we complain is found among doctors of both high and low degree. We feel hardly able to say which class is the greater offender. We are satisfied, however, that the greater the man the greater his responsibility, and the greater the evil he does when by reason of failure to recognize his responsibility he commits a fault. Ofttimes thoughtlessness in a very trifling matter works quite a little harm in the end. We are especially concerned at the present time over individual responsibilities in the profession.

At society meetings evidence of thoughtlessness is often found in remarks made in debate. A physician reads a paper. Some deservedly popular colleague, in rising to debate the subject presented, gives the paper almost unqualified praise, perhaps expressing a mild dissent from the views expressed by the author; and yet among the debater's personal friends his views are known to be radically different from those of the essayist. His good nature, his desire to make the essayist feel happy in the possession of the approval of his fellows, his detestation of a "row," leads him to commit a professional crime, which mature deliberation makes him detest. To our way of thinking there is no excuse for this course, for it is to be expected that men shall disagree. It is no disgrace, therefore, to hold opinions different from the speaker, and holding such opinions, it is of the highest importance that the dissent therefrom be boldly expressed. It is not necessary to use language that shall stir opposition and arouse ire. On the other hand, the essayist owes it to his fellows to receive all criticism in the spirit in which it is given. His mere act of presenting his views publicly is a direct invitation for criticism, and not for fulsome adulation. He must not feel hurt,

therefore, if his views are courteously opposed, or if his personal friend, Dr. X. Y. Z., argues against his conclusions or endeavors to show the falsity of his premises.

Such a simple act as the giving of a small sum of money to an ostensibly charitable object is likewise an evil not appreciated by us. To illustrate: A well-dressed woman called on a physician soliciting aid for a deceased physician's family. She presented a list of donors to the amount of one dollar each that included some two or three hundred of the most prominent medical men of the city. These obtained, lesser lights were now interviewed, and these feeling that a dollar was not much (though they could not afford to part with it) felt that they must follow the example of their more distinguished colleagues. The solicitor was a fraud. Each subscriber to the fund was not only swindled out of his contribution but also acted as a tool in the hands of the swindler, for by affixing his name to the list he practically endorsed her honesty, and thus aided her in duping the next victim. No doubt in some cases busy doctors contributed the dollar because it was cheaper to be cheated out of it at once than to waste valuable time in resisting the woman's solicitations.

In the matter of book subscriptions and book endorsements there is likewise a responsibility. Here, however, we feel that no one has a right to complain if he allows a wily agent to get him to buy a book simply because Dr. — subscribed. Dr. — may not have bought the book because he approved of it; on the other hand, he may have wanted it as evidence of unreliability on the part of a would-be-authority, or because he is an enthusiastic collector of all literature pertaining to a certain branch of medicine. Or, again, Dr. —'s tastes lead him to prefer a certain style of literature that is not adapted to the requirements of the practical medical men.

In giving introductions of itinerary merchants to colleagues care should be exercised. That such introductions are given wantonly we deny. That they are worded thoughtlessly we know. If a man has served one of us faithfully it is only necessary to state such a fact, and not to deduce from the same the broad generalization that he will serve all likewise. To illustrate once more: A man called with samples of cloth which he was enabled to sell at startlingly low rates by reason of some "hocus pocus" excuse that we could not well understand. He brought with him letters of introduction from eminent medical men and ministers of the city. He had sold them good cloth at a sacrifice, and armed with their testimonials he proceeded to carry on his swindling operations throughout the

city. And still another: A man called representing himself as the inventor of a certain little appliance which he exhibited, and for which he asked a certain price. He brought with him letters and certificates from well-known physicians of New York, Boston and Philadelphia. Our acquaintance with many of those who gave the letters of introduction enabled us to say that the letters were genuine. The man was a fraud. His device was not his own patent; and it could be bought in the shops for about one-third the price he asked for it. One of the great New York medical weeklies has but recently paid its respects to this man, exposing his conduct. Physicians should be just as guarded in giving letters of introduction to others, as a gentleman would be of whom he introduces to his family. The dignity of the profession demands such care.

No less important is the giving of testimonials to manufacturers of instruments, proprietary preparations, etc. If one honestly believes after proper experience that certain things are the best, and deserve professional support, or should come into general use, and providing he knows what he is endorsing, there can be no objection to his doing so. But he assumes a responsibility. Have not many of us given advice in the past that wiser years have since taught us was wrong? If such advice by word of mouth is fraught with wrong, how much worse is that put on paper and which lives on forever, hereafter always ready for use regardless of changed circumstances.

As to quackery, let there be none of it. At the present time we know that there is a great would-be system for the cure of drunkenness being paraded over the land. Much free advertising has been given it by lay journals. But this has not ended the evil. Many physicians hitherto financially unsuccessful in practice have taken it up and are practising it, not because they believe it to be good, but because they know it will make money for them. We have been informed that the ex-president of a State Society has been tempted to his downfall by this form of quackery. He is now practising the "cure" (?), and is apportioning out districts to the profession of his State. He is generous with his favors, allopath or homœopath; whichever will pay the most, secures his patronage. We do not apprehend that this man will delude many of the worthy and intelligent, for the quackery is so transparent that he who runs may read. His downfall may give those willing to listen to temptation a plausible excuse for doing likewise, but it can never tempt those who do not want to be tempted. On the general public it has a far different

effect. It leads them, on the one hand, to lose their respect for the profession, and, on the other, to use quackery for themselves and their families. This ex-president of a State Society then has not honored those who honored him; he has not appreciated the responsibility his high position placed on him. His constituents who honored him will not appreciate their responsibility before the public if they do not purge themselves of his dishonor.

THE WASHINGTON MEETING.

THE Washington meeting of the American Institute of Homœopathy was a success in every respect. In the first place it was the largest meeting ever held by any body of homœopathists, no less than twelve hundred members and visitors being in actual attendance. In the second place, it was a successful meeting from a scientific standpoint; and lastly, it was rendered memorable by the great hospitality of the Washington physicians, and their lady friends. We are sure that the visiting members will never forget the attentions shown them.

Discussion, which at other meetings lagged, at Washington was a prominent feature. The gynæcologists found the time assigned to them altogether insufficient, and held no less than four sectional meetings. The gynæcologists have always been good talkers, but on this occasion they outdid themselves. Other bureaus held equally profitable meetings, though not requiring the time taken by the gynæcologists. Many excellent and really classical papers were presented, some of which will appear in the *HAHNEMANNIAN*.

As to the social features of the meeting, they were, as we said before, a complete success. Beginning with Monday evening, when the public meeting was held in the National Theatre, and ending with Thursday, there was one big round of pleasure provided for the delegates. The public meeting was certainly a success. The large opera house was filled to overflowing, while the stage settings were of the most elaborate description. The electrical display about Hahnemann's portrait hung over the stage awakened the enthusiasm of the audience, and elicited storm after storm of applause. The illustrious coterie of speakers who graced the occasion added to the pleasure of the audience.

As to the excursion to Mt. Vernon and the collation at Marshall Hall, it was as successful as all the other features. Over nine hun-

dred went down the Potomac on the steamer, and this vast throng after visiting Washington's resting-place, proceeded to Marshall Hall, where a most remarkable collation was served. Rarely, if ever, we may venture to assert, have so many been seated to a course dinner in the woods and with such little apparent difficulty.

A number of members were sick. Kentuckians suffered along with the rest. Yet Washington water was blamed for it. We think, however, that when doctors eat crab-salad and follow it with ice-cream, they must expect to suffer as do other ordinary mortals under like circumstances. We are not unmindful that the Congress of Physicians that met in Washington last September likewise suffered nominally from Washington water. But we fear that they were the victims of the many good things with which hospitable Washingtonians beguile their visitors.

The next meeting will be held in Chicago, and will be in conjunction with the World's Homœopathic Convention. Chicago's 400 (this means Chicago's homœopathic physicians) will have hard work to outdo Washingtonian hospitality; but it is said that the men from the Windy City are capable of almost anything. We trust that the Committee of Arrangements will not follow the example set by the Atlantic City meeting and abandon the sectional meeting. Let the plan of Institute work be uninterrupted, and let our foreign visitors see a sample of American work and brains.

OFFICIAL RECOGNITION OF HOMŒOPATHY IN PHILADELPHIA.

THE homœopathic physicians of Philadelphia never having received any official recognition by the city authorities, the members of the Homœopathic Medical Society of the County of Philadelphia, on April 14th, 1892, petitioned the City Councils to favorably consider an ordinance to appoint, in each of the medical districts of the city, a reputable homœopathic physician, whose duty it shall be to furnish gratuitous medical treatment to the worthy poor applying for the same. Dr. Chas. E. Karsner introduced the ordinance; it received the favorable recommendation of the Joint Committee on Charities and Corrections, and passed both branches of Councils by large majorities. It was promptly signed by Mayor Stuart, and it is now the law of the city that there shall be twenty-five homœopathic physicians to the out-door poor. An ordinance was also passed that two of the four medical inspectors—city positions recently created—shall be held by homœopathic physicians. These latter positions carry with them large salaries, and the appointments are made by examination according to civil service regulations. A large number of physicians should apply for examination, as it is open to all.

OBITUARY.

DR. C. E. LANING.

DR. CHARLES ELMER LANING, of Chicago, Ill., died May 21st, at his residence 2972 Calumet Avenue, after a severe illness of two weeks. Dr. Laning was born at West Bethlehem, Washington County, Pa., April 26, 1851, and had been a resident of Illinois for the past seventeen years. As all great men seem to be the outgrowth of vicissitudes, so Dr. Laning in his early life was obliged to struggle for his education.

After graduating from the Chicago University, he entered upon the study of medicine, and graduated from the Hahnemann Medical College of Chicago in 1878. Throughout his student life he was noted for his retentive memory and acute perception. With these native elements together with untiring energy, he became early recognized in the medical profession.

From 1879 to his death he occupied a prominent position in the Faculty of the Hahnemann Medical College. His extensive knowledge of anatomy and materia medica coupled with a native intuition made him conspicuous as a diagnostician and unequaled as a prescriber. Dr. Laning was versatile in his thought, and always ready to accept new ideas, and the advanced steps in medical progress.

He was born a frail child, and his early life was threatened. Realizing the necessity of having a body as well as a head, he began a systematic thorough course of training, and became an athlete in physique.

At the time of his death he was at the zenith of his manhood. His social nature gained for him a large circle of friends, and his brilliant mind an army of admirers. The profession at large began to realize his merit, and will now deeply deplore his loss.

He had a noble generous heart, and his willing arm was always extended in behalf of the suffering poor. While he was eccentric in many of his ways, he was honest in thought and noble of purpose.

He did not seek notoriety in fashionable life, but was better pleased to devote his time and energy to the calling he had chosen.

In his death a great medical light has gone out; he will be missed by all who knew him, and the medical profession has received an irreparable loss.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D.,

FRANK H. PRITCHARD, M.D., AND EDWARD M. GRAMM, M.D.

INSUFFICIENCY OF THE VALVES OF THE PULMONARY ARTERY.—Prof. Gerhardt, of Berlin, read a paper on this subject, at the last congress of Internal Medicine. This disease has been regarded since Skoda's time as the most infrequent of heart diseases. The writer, however, has observed twenty-nine undoubted cases, where the diagnosis was confirmed anatomically. Only a fifth of these were to be traced to acute articular rheumatism, the remainder being due to puerperal fever, traumatism, gonorrhoea, syphilis, etc. Congenital anomalies are frequent. The thin valves of the pulmonary artery are easily destroyed, hence they are found to be perforated or to have disappeared, often from pressure, due to aneurism, etc. Typical cases are rare, for other valvular diseases of the heart are generally present, especially those of the aorta. Sometimes the insufficiency is only relative, due to dilatation of the pulmonary artery. The disease may appear at any age, in children as well as in very old persons. Enlargement of the right ventricle is indicated by an increase of the dullness lower down, which is favored by an elongation of the pulmonary artery. The diastolic sound is found especially at the left border of the sternum and it increases in intensity on breathing. It has a deeper sound than that of aortic insufficiency. It should be differentiated from embolic processes of the lung as well as from hemorrhagic infarcts. The patients sometimes appear pale but not always. The pulse is somewhat increased in frequency. The insufficiency leads to similar changes to those found in aortic insufficiency, hence one will observe dilatation and elongation of the arteries, they taking on a serpentine course. In the lung this may be substituted by an increase in volume and density of the pulmonary tissue. If one auscultate far away from the heart one will hear a distinct double sound, which is also to be heard in very pronounced cases of aortic insufficiency. Sometimes one will perceive vesicular breathing interrupted and spasmodic, at a distance from the heart. As a differential diagnostic point between aortic and pulmonary insufficiency, one may mention that in pulmonary insufficiency there is no diastolic sound to be heard over the aorta while aortic insufficiency presents this sign.—*Berliner Klinische Wochenschrift*, No. 20, 1892.

DOUBLE CRURAL SOUFFLE IN AORTIC INSUFFICIENCY.—Dr. Azoulay states this sign to be one of the most reliable indications of aortic insufficiency. Yet, in order to obtain it, one must take certain precautions. The patient should be placed in the horizontal position, in bed, a pillow is placed under his head, he lifts his arms without making any effort, however, and an assistant elevates the extremity of the side which one does not intend to auscultate by means of the great toe, keeping it at an angle of 30 to 40 degrees with the bed. If no assistant be at hand one may bend the knee as much as possible, the foot resting on the bed. The stethoscope is then placed over the artery, at Poupart's ligament, pressing slightly in order to get the first sound, then, if one press harder the second will be perceptible. The two sounds should be heard successively. In this manner the writer has succeeded in auscultating this souffle, in aortic cases, where it had been impossible to obtain it before. In cases where the souffle was perceptible this position has rendered it more clearly audible. The first sound is always stronger and the second more distinct than in the sitting position. The author has employed this manœuvre in all cases of central and peripheral souffles of cardiac, pericardiac and vascular origin.—*Le Bulletin Medicale*, No. 37, 1892.

A METHOD OF INCREASING THE INTENSITY OF HEART SOUNDS.—Azoulay (*Gaz. des Hop.*) communicated to the Academy of Medicine of Paris, a method of procedure which allows of the more easy detection of cardiac bruits when they are

only slightly marked, and which is capable of bringing them into evidence when they are absent during our examination of the patient. It consists in making the patient lie as horizontal as possible, with the arms raised above the head, and the head and legs raised as much as possible on cushions. Cardiac tension is thus increased and the physical signs are accentuated.—*British Med. Journal Supplement*, June 4th, 1892.

EXAMINATION OF THE BLOOD.—Rosin says that the centrifugal machine has already rendered considerable service in the examination of the urine. In the case of the blood it may also be used to estimate the deposit which consists of corpuscular elements. The author expected to find this deposit diminished in the anaemic, and a certain average in the healthy. The difficulty lies in the coagulation of the blood. To prevent this, 4.5 c. cm. of sterilized peptone saline solution is added to 0.5 c. cm. of blood. This is diluted to five times its original value, and 5 c. cm. put in a specially constructed funnel shaped glass, and placed on the machine. The blood taken from the veins of two anaemic patients showed a striking difference from that of two healthy individuals, but the blood from the finger gave varying and unreliable results. In the capillary circulation there is considerable variation in the concentration of the blood, and this may also explain why other methods such as counting the corpuscles, do not always yield the results expected.—*British Med. Journal Supplement*, June 4th, 1892.

HÆMOPHTYSIS IN RENAL CIRRHOSIS.—At a meeting of the London Clinical Society, Dr. Francis Hawkins gave an account of a case of renal cirrhosis in which profuse hæmoptysis occurred, the symptoms simulating those of pulmonary tuberculosis. The heart was much hypertrophied, and there was general arteriosclerosis. There was slight dulness over the left infra-clavicular region and decided dulness, with moist râles over the left infra-scapular region. The urine contained albumin and hyaline casts, and micturition was frequent. As the hæmoptysis was associated with increased arterial tension, iodide of potassium was given with beneficial results. Subsequently the case passed into other hands, and ergot was given, which increased the bleeding. The diagnosis of renal disease was verified post-mortem; the left lung was then found to be carnified at its base, emphysematous and oedematous at its apex. The right lung was emphysematous, congested, and oedematous. Dr. Hawkins drew attention to the fact that hæmoptysis might occur as a symptom in renal disease, and that a hypertrophied heart might produce physical signs in the left lung which might be mistaken for those of tuberculosis. He also pointed out that ergot often produced an increase rather than a diminution of hæmoptysis.—*Medical Record*, June 18, 1892.

OBSERVATIONS ON THE EXCRETION OF URIC ACID IN HEALTH AND DISEASE.—Drs. C. A. Herter and E. E. Smith in their observations on uric acid, treat of their subject under the following headings: 1. The methods used in determining uric acid and urea. 2. The variations in total uric acid excretion under the influence of diet, exercise, etc. 3. Variations in total urea under the influence of diet, exercise, etc. 4. The quantitative relation of uric acid and urea in health. 5. The excretion of uric acid as influenced by drugs. 6. The excretion of uric acid in disease.

As to the method employed for the estimation of the quantity of uric acid, the authors express a decided preference for the method of Ludwig-Salkowski, described in Neubauer and Vogel's work on the urine. The method, however, is not adapted to clinical work. The same is true of all other methods thus far proposed. For the estimation of urea, they recommend either Kjeldahl's process or the well-known hypobromite method.

Recent investigation have made it probable that uric acid is formed in the liver and spleen. There seems to be no satisfactory evidence that it is formed in the kidney. The quantity of uric acid excreted daily by a normal adult varies considerably, and this variation depends more upon the character of the diet than upon any other factor. A highly nitrogenous diet increases the excretion of uric acid; a diet poor in nitrogen diminishes it. The mere total quantity of uric acid, however, gives no knowledge as to whether this quantity is or is not excessive. In order to obtain this knowledge it is essential that we should know the total quantity of urea excreted during the twenty-four hours. Exercise increases somewhat the elimination of uric acid. The differences in uric acid excretion are not exactly proportioned to the body weight of the individual. Thus from the second year of

life to puberty, the quantity of uric acid contained in the urine, is distinctly greater in proportion to the body weight than in adults.

The quantity of urea is proportioned in a general way to the amount of nitrogenous food assimilated. This is a most important fact, for it thus happens that the quantity of urea excreted is an index of the activity of the nitrogenous metabolism of the body. If an adult (of 150 pounds weight) is regularly excreting a large amount of urea daily, this is good evidence that there is extensive tissue waste, and if the individual is not losing weight, we know that he must be assimilating a large quantity of nitrogenous food. Exercise has but little effect on the elimination of urea.

The authors find that the normal relation between uric acid and urea excretion ranges between 1.45 and 1.65 in adults. A relation lower than 1.70 is probably not met with in normal adults on a mixed diet. On a bread or milk diet the relation may easily run as low as 1.80. It is essential in making these estimates that twenty-four hours' samples of the urine be used, for the ratio between the two substances varies at different times of the day, and a partial sample may not be a reliable index. The authors dissent from the conclusion of Haig, who places the normal uric acid urea relation at 1.33. This they consider altogether too high, and invariably abnormal.

As to the influence of drugs upon uric acid excretion they find that alcohol as whisky does not, in healthy individuals, exert any influence. When, however, champagne is taken, the elimination of uric acid becomes rapidly less. Salicylate of soda increases uric acid excretion. The influence of quinine is not altogether understood. In moderate doses, it apparently diminishes uric acid excretion out of proportion to the urea excretion. As to antipyrine, one observer found that it diminished, and the other that it greatly increased excretion of uric acid. Antifebrine has been found to increase the excretion of urea, and diminish that of uric acid.

The authors' work relating to the excretion of uric acid in disease relates chiefly to chorea, epilepsy, neurasthenia and migraine. In four cases of chorea, there was a continuously excessive excretion of uric acid. This excess appeared to be proportioned to the severity of the choreic movements. As to epilepsy, they have not as yet obtained any evidence that the grand mal paroxysms of epilepsy are regularly or even usually preceded by a diminished uric acid excretion as claimed by Haig. On the other hand, their results support the view of Haig to the extent that they find the paroxysm to be usually followed by an increase in the uric acid of the urine. In many cases this increase is greatest on the second day after the paroxysm. This latter fact suggests that the increase in uric acid is the result of conditions that are associated with and perhaps determine the paroxysm, and that this increase is not itself a cause. Some observations suggest that uric acid is a factor of some significance in cases of petit mal. That this excess has been in some degree related to the petit mal seizures in three cases, was shown by the cessation or reduction of the seizures by the use of a diet which lessened uric acid excretion.

Analysis of the urine from nine cases of neurasthenia showed in each instance but one an excess of uric acid. In four of the cases the neurasthenic symptoms were the result of sexual excess. A marked feature in some of the cases was a tendency to rather sudden variation in the ratio of uric acid to urea.

In migraine an increase of uric acid was noted after the attack; but no diminution beforehand.

In conclusion the authors observe that there seems to be no evidence to show that the formation of uric acid is a necessary precursor to the formation of urea. Such evidence as there is points to the idea that both of these substances are the consequences of a more or less lengthy and varied series of metabolic changes, and that the formation of uric acid is expressive of merely a slight divergence from the process that ends with the production of urea. An increase in the formation of uric acid such as to make the quantity in the urine bear a higher relation to the urea of the urine, is to be guarded as the result of a derangement in the development of the chain of nitrogen holding substances that make their successive appearance for a short period of time between the commencement of digestion and the completion of destructive metabolism. What these substances are and how they are related to one another is still largely unknown to us, but there seems nothing unreasonable in the view that in conditions of disease in the early links in the chain may differ from those that belong to health, and may possibly present a considerable divergence among themselves in the different morbid processes.

But whatever may be the character of the original disturbance or of the morbid substances concerned in it, as destructive metabolism progresses, there are only a few substances, so far as we know, though which these concomitants of deranged nitrogenous metabolism may be eliminated from the body. Of these, one of the most important appears to be uric acid.

According to this view, then, the increased excretion of uric acid that is met with in disease might be an effect of numerous different derangements in nitrogenous metabolism. We believe that this suggestion harmonizes with the fact that uric acid increase may be brought about by so many nutritional disorders. In this excessive excretion we should be dealing with the result, and probably not with the cause of disease. Excessive uric acid formation, in other words, in a terminal process that may result from different and perhaps numerous initial morbid nutritive conditions. The fact that they cannot now point out what these derangements consist in or with what poisonous substances they are identified, does not make less reasonable the view suggested by the authors.—*New York Medical Journal*, June 4, 1892.

SUDDEN DEATH IN PLEURISY, PNEUMONIA AND THE GRIPPE.—Dr. Huchard, of Paris, France, calls attention to the important influence of the grippe, pneumonia and pleurisy in developing latent heart diseases and subsequent sudden death. The grippe is especially liable as the toxine of this disease acts on the medulla oblongata and pneumogastric nerves, paralyzing them, as well as on the arterial tension, in such a manner as to cause embryocardia to appear. The first signs are, arrhythmia, acute systolia or tachycardia. Arterial cardiopathy is latent in its course, and insidious in its beginning. A simple bronchitis, a pulmonary congestion or a pneumonia are sufficient to precipitate their progress or accentuate their symptomatology. The same thing holds true of sudden death in pleurisy. The writer has had three cases come under his observation which were of this order and in each case he was able to confirm the presence of pre-existing coronary lesions. Sudden death, on the contrary, is hardly ever observed in pleurisy in children.—*La Semaine Médicale*, No. 27, 1892.

RECTAL GONORRHEA.—Dr. Frisch reports the case of a patient, who had performed coitus per anum several times, and who afterwards suffered from burning pains in the rectum, which were most violent after stool. He also had, at the same time urethritis. The secretion issuing from the anus contained numerous gonococci, which were either free or inclosed in round cells. On examination with the speculum the rectal mucous membrane was found to be very hyperæmic, swollen and covered with a layer of pus. Two inches above the anus there was a superficial and irregular ulcer, of quite large size. The disease was very obstinate. Six months after treatment with sitz-baths, irrigation, introduction of medicated tampons, etc., the patient died of phthisis. Histological examination of the mucous membrane showed an atypical development of the acinous glands, with proliferation of the connective tissue, at the border of the ulcer, while Lieberkuehn's glands were destroyed. The mucous membrane, as far as the muscular coat, was infiltrated with small, single round cells. Gonococci were found free on the surface and inclosed in the polynuclear round cells. The writer is of the opinion that many cases of apparently syphilitic rectal ulceration, in women, are often of gonorrhœal origin.—*Norsk Magazin for Lægevidenskaben*, No. 5, 1892.

GRAVE ANÆMIC STATES.—Prof. Birch-Hirschfeld, of Leipsic, divides these states into three classes: ordinary secondary anæmia, chlorosis and progressive pernicious anæmia.

Secondary anæmia is proportional to its causes. It does not overstep the boundaries of the clinical picture, even if it be extreme. In this form the red blood corpuscles are decreased in number while the white corpuscles are absolutely or relatively increased. The hæmoglobin of the single blood corpuscle is but little or not at all changed. In chlorosis the debility of the hæmopoietic organs is manifest. The blood changes, as a rule, show but moderate or no alterations in the number of blood corpuscles, but, on the contrary, the quantity of hæmoglobin in the single red corpuscle is greatly reduced.

In two cases which came under the observation of the writer and where in both death took place, from embolism of the pulmonary artery, the necropsy did not reveal fatty degeneration of the heart, liver or kidneys.

Progressive pernicious anæmia is characterized by changes in the blood and tis-

sues. The blood shows great diminution of the coloring elements, the appearance of retrogressive forms as microcytes poikilocytes, products of degeneration and earlier stages of development of the red blood-corpuscles, as the nucleated and colored substances as well as the large and nucleated erythrocytes. The necropsy reveals, besides punctate hemorrhages into the serous membranes, the retina and mucous membranes, the well-known fatty degeneration of the heart, liver and kidneys, which is characteristic. This fatty degeneration is the direct result of the anæmia and occurs during life. As a proof of the tissue degeneration Eichhorst points to the relatively large quantity of urea contained in the urine. Recently v. Jaksch and Lussana have demonstrated peptonuria to be characteristic of this disease. From examination of the urine, made in the Leipsic pathological institute two cases of very severe chlorosis did not present peptonuria at any time. In grave secondary anæmia, from carcinoma of the stomach, cancer of the peritoneum, hepatic cirrhosis, etc., peptonuria was observed now and then. On the contrary, a case of progressive pernicious anæmia presented peptonuria for eighteen consecutive days. These grave anæmic states are due to various causes, yet the clinical picture is much the same, as are also the course and anatomical findings. In anchylostomiasis the grave anæmia is not sufficiently explained by the loss of blood, through the parasite, but the parasite must give off some toxic principle. Anæmia has been traced to the presence of other parasites, as the bothriocephalus, and trichocephalus. The influence of small repeated hæmorrhages, pregnancy and childbirth on pernicious anæmias is undoubted and striking. Bad food has an important action in the development of progressive anæmia, yet, as Biermer has shown, the blood is no more affected than the remainder of the body. Still, a large number of pernicious anæmias have been observed to develop under favorable conditions. Explanation of the hæmorrhage is difficult, on account of our knowledge of the formation of the blood being so meagre. If the marrow of the bone be regarded as the place of formation of the red blood corpuscles, then but few cases of disease, having their seat here, primarily, are known, as for example, sarcomatous tumors. The so-called fetal transformation of the marrow is probably of degenerative origin, and the consequence of the anæmia. This change may be present in a simple anæmia and absent in pernicious anæmia. In pernicious anæmia, as a rule, the spleen is not enlarged. In pernicious anæmia the red blood corpuscles degenerate and deposits of iron take place in the liver, kidney and spleen. Indeed, the destruction of the red blood corpuscles is often so rapid that pigment deposits are found in the liver, kidneys and marrow of the bones. Progressive pernicious anæmia often commences with icterus. The blood shows a striking tendency not to coagulate, as well when removed from the body as when in the cadaver. In chlorosis, on the contrary, the blood coagulates quickly and thrombosis occurs quite frequently in the large veins of chlorotic patients. This is not true of those suffering from pernicious anæmia. In pernicious anæmia the plasma seems to be altered. Many cases are apparently due to the taking up of substances undergoing degeneration into the blood current. In cases complicated with pregnancy and childbirth the source of these would be seemingly, the placenta. Hence grave anæmic states are characterized by diminution of the number of the blood corpuscles and their degeneration and destruction in the tissues, heart, liver and kidneys. The hæmopoietic organs are unable to keep up with the increased destruction of blood corpuscles and, hence, those produced are imperfect, microcytes and poikilocytes, and disposed to destruction. Various injurious factors may produce this by acting either directly or indirectly on the corpuscles or plasma. These factors may be external toxic agents, specific microorganisms formed in the body or depending upon retrogressive changes in the tissues, auto-intoxications. The following are the most frequent causes: repeated hæmorrhages, post-hæmorrhagic form, digestive disturbances, the dyspeptic form, parasites, pregnancy and the puerperium, and, finally, infectious processes, as syphilis and malaria. Another form remains to be mentioned, the idiopathic or cryptogenetic form, dependent upon destructive substances, poisons, toxines or enzymes. Dr. Dehio, of Dorpat, Russia, has treated several cases of grave anæmia, due to the parasite bothriocephalus. He often found that the worm was, at the necropsy, no longer to be found in the body and regards the death of the parasite as the cause of the anæmia.—*Muenchener Medicinische Wochenschrift*, No. 17, 1892.

LIME IN THE SALIVA.—An examination of the saliva for lime gives results of a variable character. A series of observations have been made by Lepkowsky on the subject in the hope of elucidating the cause of this variation. The method em-

ployed was that recommended by Kruger. In perfectly normal cases the saliva contained from 2 to 3 per cent. of lime, there being more a few hours after a meal, than either just before or after it. A rise of body temperature, too, appeared to cause an increase in the amount of lime. Where any of the teeth were affected by caries, the lime increased to from 3 to 5 per cent. It did not appear to matter whether only one tooth or several were affected. The lime was evidently not dissolved from the teeth, for in the three-quarters of an hour during which the secretion was collected for analysis, the utmost that could have been dissolved from the teeth was 0.000,004 gramme—a quantity too small to be detected chemically. Again, it was found that a still larger proportion of lime occurred in the saliva of persons who had lost all their teeth, in whom it contained from 6 to 9 per cent. Dr. Lepkowski has not found himself in a position to advance any definite theory as to the cause of variation in the amount of lime, but suggests that nervous influences play a not unimportant part in its secretion.—*The Lancet*, June 4th, 1892.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

INTRACRANIAL NEURECTOMY OF THE SECOND AND THIRD DIVISIONS OF THE FIFTH NERVE.—Hartley (New York) has successfully practiced a new method to get at the Casserian ganglion in a case of obstinate prosopalgia for which the infraorbital and inferior dental nerves had been resected, and thirty-one teeth had been drawn without relief.

An omega-shaped incision was made down to the periosteum. It formed part of a circle three inches in diameter, the curved portion reaching to the supra-temporal ridge, and the ends resting on a line drawn from the external angular process of the frontal bone to the tragus of the ear. The periosteum was divided, and a groove chiselled in the bone along the same line. This groove went to the vitreous plate, except at the upper portion where the two plates were divided. By means of a periosteal elevator the bone was snapped and a flap consisting of the soft parts and bone turned down, the base of the omega acting as a hinge. After tying the middle meningeal and raising the dura and brain with broad retractors, the foramen rotundum and ovale, the three divisions of the fifth nerve, the carotid artery and cavernous sinus were well exposed. The second and third divisions were isolated at their foramina of exit, and, by pressure on the dura, freed to beyond the ganglion. They were excised between these two points and the distal ends pushed through the two foramina. The flap was raised and stitched in place, the ragged edge of the vitreous around the opening serving as a shelf to prevent its pressing on the dura.

Six weeks afterward the patient was free from pain and had gained in weight. Ptosis, external ophthalmoplegia, and diplopia were present, but disappeared subsequently. The paralysis of the pterygoids, temporal and masseter caused but little inconvenience as the patient had for ten years chewed his food on the other side.—*New York Medical Journal*.

REMOVAL OF THE SEMILUNAR GANGLION.—Andrews (Chicago) has twice removed the Casserian ganglion through the floor of the skull for obstinate facial neuralgia which had resisted other nerve resections. The technique differs somewhat from that followed by Rose in his first three cases:

After shaving and disinfecting, a perpendicular incision was made across each end of the zygomatic arch, which were connected by another one along the arch, forming the letter H. The two ends of the zygoma were sawn through, the bone separated from the temporal fascia, and turned down with the masseter muscle. Tearing through some connective tissue, the coronoid process was exposed, sawn off, and turned upward with the attached temporal muscle. The internal maxillary was isolated in the loose connective tissue, ligated, and divided. The external pterygoid was exposed and divided near its insertion to the neck of the jaw; beneath it the inferior dental, and then the gustatory nerve were recognized and divided, the stumps being held by clips as a guide to the foramen ovale. As a further

guide the finger was passed along the posterior free border of the external pterygoid plate, which usually runs exactly to the anterior extremity of the foramen, although it may, in some skulls, be prolonged in a ridge on the inner or outer border of this opening. A little search with a probe will find the opening. The muscular attachments from the level under-surface of the bone external to the foramen were scraped off, and a five-eighths inch button removed with the trephine. The bridge of bone intervening between this opening and the foramen was bitten off with rongeur forceps. Drawing the divided nerves outward, the capsule was opened, a small Volkmann spoon introduced and the ganglion destroyed. The superior flap was drawn down and the coronoid process wired to the jaw; the inferior flap was raised and the zygoma similarly treated, and the soft parts sutured.

In one case there was ptosis and paralysis of the third and fourth nerves which disappeared in a great measure. Corneal ulcerations were healed with a boracic acid wash and wet compresses. At the end of five months the patient, who had been bedridden before the operation, was restored to health and still free from pain.

In the other case the ocular nerves were not injured, and, a month after the operation, there was no recurrence of the pain.—*International Medical Magazine*.

ACUTE URINE FEVER IN SURGICAL PRACTICE.—Harrison (London) gives the following cases as types of the varieties of urinary fever met with in practice:

1. Internal urethrotomy, in subject with healthy kidneys, followed by rigor, fever and sweat; recurrence of same; rapid, good recovery. (It is a question of interest whether, during this operation, a instrument was passed *through* the deep urethra *into* the bladder. Such a procedure has been quickly followed by death in one reported case, and, by avoiding this, we have an experience of more than one hundred cases cut to the bulb without chill, fever, or troublesome hæmorrhage. Eds.)

2. Passage of a small bougie through a long tight (anterior) stricture, which had been done before on several occasions. In half an hour, recurring chill and vomiting, convulsive tremor, and death in six hours. The autopsy showed nothing but congested kidney.

3. Catheter *à demeure* after traumatic rupture of the membranous urethra. On the second day repeated convulsions with opisthotonos, temperature of 104°, and death in eight hours. No autopsy.

The writer considers these undoubted cases of infection. On the other hand these accidents do not occur after suprapubic or perineal lithotomy, while they are frequent after internal urethrotomies or traumatic ruptures of the deep urethra. In view of these observations Harrison again urges the performance of a *boutonnaire* after internal urethrotomy.

Another observation, which is considered of nervous origin, is shown by the two following cases:

1. Perineal section to remove fragment impacted in the deep urethra during a lithotripsy. The tube was removed on the twelfth day, the temperature having remained normal. After the first natural micturition there was a rigor, and a rise of temperature to nearly 101°, followed by uninterrupted recovery.

2. Perineal section, division of the prostate and drainage. Natural urination, on the twentieth day, was followed by chill, headache, fever (101.40) free diaphoresis.—*Revue de Chirurgie*.

STONE IN THE BLADDER.—Dittel (Vienna) reports his seventh hundred operation for vesical calculus. The apparent mortality of twenty per cent. for the thirty epicystotomies can, on analysis, be reduced to about three per cent. So too with the three cases of perineal lithotomy, the one death would have followed any operation. Lithotripsy at one sitting is the writer's operation of election (one death in sixty eight cases) on account of the low mortality, short convalescence, and the absence of complications. But it is the more difficult operation, cannot be practised on the cadaver, and therefore, must give place to the high operation with the average surgeon who lacks practice and dexterity in the urethra. The contra-indications to crushing are:

1. Large, hard, encysted, or "pipe" stones.
2. Presence of extensive, hard strictures, and urinary fistula.
3. Large prostates, particularly when prostatectomy may be required.
4. Severe cystitis, purulent, hæmorrhagic, or diphtheritic.
5. Recurring stones (after crushing).
6. Young patients.—*Wiener Klinische Wochenschrift*.

COCAINE IN GENITAL IRRITATION.—Wells (U. S. N.) calls attention to the value of this drug in soothing sexual irritability in men. Examinations of the male sexual organs after the use of cocaine in the nose or pharynx showed retraction and reduced sensitiveness of the glans penis; occasionally the scrotum was drawn up. A four per cent. solution internally relieved three cases of troublesome erections. In three others local applications to lesions removed the accompanying annoying erections.—*Therapeutic Gazette*.

SURGERY OF THE TONGUE.—Dandridge (Cincinnati) presented a review of the subject of malignant disease of the tongue to the American Surgical Association. As a rule the growth is an epithelioma and runs its course in about a year and a half, the glandular involvement occurring as early as three or as late as nine months. It may develop from an indifferent lesion which has been subjected to long continued irritation. When ulceration begins the distinction from tubercle is difficult. (We have found the same true in two cases of primary syphilitic, and one of gummatous ulceration until cleared up by appropriate treatment.—Eds.)

The following are the operative methods to be preferred:

1. *Whitehead*.—The sitting posture is used and the jaws separated by a gag, care being taken to avoid impeding the respiration. A ligature is passed through the anterior part of the organ, which can be freely drawn forward after complete division of the fraenum and the anterior pillars of the fauces. The tongue is then amputated with scissors, the main artery being caught before division, and, before completing the section, a loop of silk is passed through the glosso-epiglottidean fold to control the posterior floor of the mouth. Whitehead's mortality is 19.2 per cent, fifteen patients in sixty-one living one year; four, two years; three, three years; four, five years; and one, six years.

2. *Mordant Baker*.—Two threads are passed half an inch on either side of the median line. The attachments of the tongue are divided close to the jaw and the organ split in the median line, the diseased half being removed with the *ecraseur*. Infected glands are attacked by an external incision.

3. *Kocher*.—The patient is tracheotomized and the fauces plugged. An incision is made along the anterior border of the sterno-mastoid, from the middle of which muscle another is carried to the hyoid bone and along the anterior border of the digastric to the jaw. The flap is turned up and the facial and lingual ligated. The attachments of the tongue are divided, it is drawn through the opening and removed with scissors or the galvano-cautery. The sub-maxillary fossa is then cleaned out. If the whole tongue is excised the lingual artery of the opposite side is ligated through a separate incision. In fourteen cases there was one death, but the operation is unnecessarily extensive unless the floor of the mouth and submaxillary glands are involved.

4. *Volkman*.—The patient is seated. The tongue is drawn out and the diseased portion resected with the knife or scissors; the mucous membrane is then brought together over the raw surface, or a flap of healthy tissue turned on to the stump to lengthen the organ. If the disease is more extensive, the tongue is controlled by a traction thread; an incision is made from the angle of the mouth downward and the lower jaw divided, after extracting the canine or first molar tooth. The divided portions of the bone are separated, the attachments of the tongue cut, and the organ excised. The mucous membrane is drawn over the raw surface and the bone is wired. In ninety-two cases there were but two deaths.

The important factors in the after-treatment are to get the patient up and out as soon as possible; to feed generously; to give a free exit to all discharges; and to keep the mouth sweet and clean.

The conclusions drawn are that:

1. Removal of carcinoma of the tongue prolongs life and gives a reasonable hope of permanent cure.

2. Persistent ulcers of the tongue should be treated by free excision and never by caustics.

3. Preliminary ligation of the lingual and tracheotomy are unnecessary in ordinary cases.

4. It is desirable, when possible, to leave half of the tongue in unilateral disease.

5. Thorough removal of the disease should always be aimed at and excision of glands by a separate incision is usually insufficient.—*Boston Medical and Surgical Journal*.

Lane (London) and Maunsell (New Zealand) advise taking extra time and trouble to cover the stump with mucous membrane. The dangers of infection by swallow-

ing and inhalation are reduced to a minimum and wound healing hastened. If necessary the mucous membrane of the floor of the mouth can be freed and drawn up on the stump.—*London Lancet*

OPERATIONS FOR CONGENITAL UMBILICAL HERNIA.—Benedict operated on the second day after birth. There was a lack of development in the abdominal walls causing a defect four inches in diameter. The protrusion was only covered by peritonæum. The skin was freshened, dissected up, and united by hare-lip pins. Good union resulted.—*Medical Record*.

Salmon operated a similar case twenty four hours after birth. The sac contained the greater part of the liver, which was returned, and the opening closed by deep and superficial sutures.—*Gazette des Hôpitaux*.

EXCISION OF THE RECTUM.—Brown (Leeds) suggests, a modification of the Kraske-Hochenegg operation which he has carried out successfully in one case:

The growth was too high for perineal protectomy, but unattached and freely movable in the pelvis. A preliminary left lumbar colotomy was done. A month later a flap four by four inches was turned *upward* from the back of the sacrum, its free edge being two inches from the anus, and its attached border opposite the third piece of the sacrum. This bone was divided transversely below the third foramina, the lateral attachments freed to the coccyx, and the bony flap turned downward. A sound in the bladder served as a guide to prevent injury of that viscus. After isolating the rectum, it was divided close to the anus and drawn out of the wound. By slitting up the bowel the limits of the growth were clearly defined, above which it was cut across and the opening stitched to the upper angle of the wound. The bony flap was turned up, that consisting of the soft parts turned down and stitched in place with free drainage. The peritonæum was not opened.—*London Lancet*.

TUBERCULAR DISEASE OF THE BREAST AND AXILLARY GLANDS.—Lane reported to the Clinical Society of London two such cases unassociated with similar lesions elsewhere:

One, in an unmarried woman of thirty-eight, the tumor having existed for eighteen months with recent axillary involvement. The breast and a number of caseous axillary glands were removed. There was no recurrence locally or elsewhere.

The other case was in a married woman of thirty-four, with a strong tubercular family history. During lactation a mammary abscess developed, and was followed by one in the axilla. Four years later the breast was found riddled with sinuses and the axilla filled with suppurating caseous glands. Complete recovery, without metastases, followed excision. The reporter claims that the very common chronic mammary abscesses are often tubercular, even though the axillary glands are unaffected.

TREATMENT OF ERYSIPELAS.—Schneider (Interlaken, strongly recommends a method employed with great success for several years by Neihans of Bern. If the disease affect an extremity a layer of collodion with ichthyol (ten per cent.) is painted around the limb, like a broad bandage twice the breadth of the hand, above the limit of the disease. The inflammatory action ceases when it reaches the border of the collodion. The writer has used the same method in cases of facial erysipelas by painting the surrounding healthy skin with collodion. He thinks plain collodion answers as well as that combined with ichthyol.—*Centralblatt für Chirurgie*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

THE PREVENTIVE TREATMENT OF MASTITIS.—For the adaption of the nipple to its function, astringent preparations were unsatisfactory to the writer. Oil is the natural and most satisfactory means of rendering the skin pliable and epithelium cohesive, and of preventing cracking and chapping. The writer has found the oily

combination suggested to her by Dr. J. G. Thomas to be the most successful. This ointment

R. Tincture benzoini composite,	gtt. xv.
Olei olivæ,	5℥.
Lanoline,	5vi.

M.

is applied to the nipple after each nursing for the first ten days or two weeks. Where the skin is thin and florid the areola hot and red, and nipple exquisitely tender and roughened with thin brownish crusts, hamamelis should be used, about one part of the distilled extract in four of water, kept evaporating from a thin rag covering the nipple. For an extensively eroded, weeping surface, with irregular edges, equal parts of tannic and boracic acid, applied after nursing, will sometimes rapidly relieve pain and promote healing. Cocaine applied to an erosion and washed off before nursing will sometimes render nursing painless which could not otherwise be done without agony. A paste of bismuth and mucilage acts well on such a nipple as has been described as suited to hamamelis; and occasionally a mixture of glycerine and the compound tincture of benzoin will act much better upon erosions than the tannin powder. The preferable method for drying up the milk is to forestall the inflowing of milk by the application of the straight binder as soon as the patient awakes from the first sound sleep following labor, and the derivation from the breasts by the administration of Epsom salts before the milk comes. They should be given to the point of mild purgation, two or three stools in twenty-four hours. Pressure, which lessens the blood supply, is best applied by the roller bandage. Cold, diminishing congestion and reflex irritation, may be applied by means of the small ice bag laid over the sensitive spot which was first covered with a cloth. Cold and pressure, if applied early, will abort inflammation, if the nipple is not exposed to fresh irritation and infection.

For those sluggish conditions where the breast remains engorged with doughy masses in its substance which will neither go forward nor backward, the application of heat and pressure is the only satisfactory treatment. The breast is anointed with oil, and, laying the palms of the hands opposite each other on the periphery of the breast, bring them to the centre with an increasing pressure, expelling the milk from the nipple by bringing the forefinger up against the areola with a quick motion. The breast can be so emptied without touching or giving pain to the sorest nipple. Rub out first that which lies nearest the nipple and comes most readily, afterwards the nodular mass of the engorged acini, and last the inflamed portion, when tension is diminished and it is comparatively painless. The formation of pus is always associated with great diminution in the flow of milk, and in a threatened breast where this occurs suddenly it is a sure sign of pus coming. If with the expression of the products of the breast you do not get diminution of pain and temperature, you are not working good but evil.—Virginia Davis, M.D., in the *American Journal of Obstetrics*, April, 1892.

TAMPONADE OF THE UTERUS.—H. C. Coe, M.D., says of the gauze tampon, American obstetricians have confirmed the statement of foreign writers with regard to the great value of the gauze tampon in the treatment of hæmorrhage after abortion and delivery at term due to atony of the uterus. The various uses of the tampon may be summarized as follows: 1. To control hæmorrhages; (a) from the non-puerperal uterus; (b) from the puerperal uterus.

2. To promote uterine contraction; (a) in non-puerperal cases; (b) in puerperal cases.

3. To promote healthy granulation of the raw surface, left after curetting and the removal of neoplasm.

4. To secure permanent dilatation of the cervical canal, thus favoring drainage. Two conditions are assumed to be present in every case suitable for tamponing; a uterine cavity of some size, and dilatation of the cervix, nearly or quite sufficient to admit the index finger. The cavity of the uterus, not the cervix, is tamponed. Dr. Coe uses iodoform gauze (10 or 15 per cent.) in two forms in good sized pieces, and in narrow strips rolled into bandages. The former are employed in cases of post-partum hæmorrhage, the latter in non-puerperal cases. It is introduced into the non-puerperal uterus after division and curetting, with a small pair of curved forceps, a little at a time, and carefully packed in such a way as to come in contact with the entire surface. It can be safely left in for two or three days, or even

longer, and can at once be replaced by fresh after an intrauterine injection has been given.—*The New York Journal of Gynecology and Obstetrics*, March, 1892.

THE TREATMENT OF GONORRHOEA.—Dr. Goelet said that he had adopted a plan of treatment which had given him much satisfaction. It consisted in using a suppository of cocoa butter containing ten per cent. of salicylic acid, the patient being directed to introduce one of these suppositories as high up as possible every night. Six of these suppositories has never failed him, and rarely were more than four required. The introduction of the suppository is preceded by a cleansing douche. The salicylic acid causes a complete exfoliation of the surface of the vagina. Dr. Prior packs the vagina as firmly as he would to control hæmorrhage, using for this purpose a gauze moistened in 1 to 3000 bichloride solution, and then sprinkles with powdered iodoform. Two or three dressings are sufficient to control the most virulent form of vaginitis. Such dressings should be changed as often as they become saturated with the discharge. For the relief of dysuria he found nothing better than Dr. Keyes's prescription of thirty grains of citrate of potash, given in a little syrup and water every two hours, the object being simply to render the urine alkaline and unirritating.—*American Journal of Obstetrics*, April, 1892.

GONORRHOEAL VAGINITIS.—A lotion is given of 1-5000 solution of hydrarg. bichlorid., made by the patient dissolving a one-grain tablet of corrosive sublimate to each ten ounces or two-thirds of a pint of hot water; to bathe the outside parts thoroughly afterwards; to inject in the vagina two or three times daily for the first two days; then reduced to one to ten thousand, or if much tenderness, 1-20,000; replaced if much pain by a 1-100 solution of carbolic acid. By the third day the speculum can be used, the cervix is observed, and after thoroughly cleansing the canal, strong carbolic acid or a solution of the bichloride, may be applied, followed by the application of iodoform in powder. A 5 per cent. solution of nitrate of silver is painted over the cervix and vagina, and the vagina is tamponed with iodoform or weak bichloride-gauze, to separate the walls of the vagina, the ends being brought down to the vulva; generally in at most ten days the discharge has ceased. Before pronouncing a case cured the condition of the glands of Bartholin should be observed. If any pus can be made to extrude by pressure the disease has not been eradicated and would relapse. Robert A. Murry, M.D., in *The New York Journal of Gynecology and Obstetrics*, March, 1892.

THE PREPARATION OF CATGUT.—Dr. Wm. Goodell recommends the following method of preparing catgut for gynecological operations: The unprepared gut comes in greasy coils of a dark amber color. To dissolve out the fat, these are placed in commercial ether for from twenty-four to forty-eight hours, according to the size of the gut; and if the gut is of the larger sizes, the ether is changed once. The gut is now immersed for forty-eight hours in a 1-1000 alcoholic solution of corrosive sublimate. It is then wound on glass spools by surgically clean hands and kept permanently for use in a mixture of two parts of oil of juniper to one of alcohol, which is occasionally changed. When needed for an operation, the requisite number of spools are transferred to a mixture of one part of glycerine, which has been sterilized by heat, to nine of alcohol. This gives the gut greater smoothness and pliability. Thus prepared it will last in the tissues of the body from a week to ten days.—*Archives of Gynecology*, April, 1892.

EFFECT OF CAUSTIC ON THE ENDOMETRIUM.—The caustic does not simply destroy the mucous membrane forever; on the contrary the endometrium is reproduced, but in a morbid form. The glands then undergo cystic changes. Secondary atrophy of the endometrium may occur, but more frequently that membrane is reproduced with the abnormal addition of numerous cysts, which bear glandular epithelium and increase in size. The application of the curette, on the other hand, gives rise to none of these bad and permanent results. (The chief feature in this change is a violent inflammatory process, which causes the orifices of the uterine tubular glands to be obliterated.)—L. M. Bossi, *Archives of Gynecology*, April, 1892.

THE INFLUENCE OF PREGNANCY ON EPILEPSY.—Dr. Guder, after much study of this subject, draws the following conclusions: *Epileptic Attacks* are, as a rule, absent during pregnancy, but that they were always sure to make their appearance during or after the puerperal period. The offspring of such women are predisposed to epileptic or eclamptic attacks. Epileptics should be persuaded from

marriage, and if pregnancy did occur, artificial abortion should be produced. He thought an effective means of stamping out, or at any rate of preventing children being born with a predisposition to epilepsy, would be the sterilization of epileptics by castration or ligation of the tubes.—*Archives of Gynecology*, April 1, 1892

CHLORIDE OF SODIUM IN THE SICKNESS OF PREGNANCY.—Dr. Green reports two cases. The first was seen in the seventh month of pregnancy, and very much reduced. It was decided to try the effects of small doses of chloride of sodium. It was given in five-grain doses in one ounce of chloroform water. After six doses had been taken the sickness had entirely ceased. It was found necessary to continue the medicine three times a day up to the time of delivery. The patient had a good delivery and made a good recovery. In another case a similar treatment was followed by the same result. The action of this drug seems to be accounted for by its strong antacid properties, for in the case of both patients the secretions were very acid.—*Archives of Gynecology*, April 1, 1892.

CÆSAREAN SECTION.—The objection to the tube, in the provisional ligation of the cervix, that it is liable to injure the tonicity of the muscles, is obviated by employing a large tube with thin walls, which spreads as it is drawn taut and distributes the pressure over a large surface. It is the practice of Säger and others after separation of the placenta and membranes to scrub the cavity with a fold of gauze. In the absence of infected fluids, after peeling off the membranes the uterine cavity should be left literally untouched. The endometrium is left aseptic after removal of the secundines, and antiseptic douching or scrubbing is not only uncalled for but injurious; a septic uterus on the other hand should not be trusted to the conservative operation at all, but should be amputated. With care to prevent the entrance of much blood and liquor amnii into the abdominal cavity, the usual peritoneal toilet may be almost wholly omitted. The obvious advantage of operating with deliberate preparation before the rupture of the membranes and with the patient in full strength furnishes a strong argument for an appointed time if possible, shortly before the expected date of labor. The main conditions of success in Cæsaean section are asepsis, and the accurate suture of the uterine wound. Reasonable rapidity, however, is important, and the length of time should not exceed three-quarters of an hour if the best results are to be expected. To these conditions should be added the early use of saline catharsis after operation. The writer's experience, not alone in these cases, but a somewhat extensive one in analogous conditions, leads him to place a high value on early resort to peritoneal drainage by the intestines.—Charles Jewett, M.D., in the *New York Journal of Gynecology and Obstetrics*, March, 1892.

OÖPHORECTOMY FOR THE CURE OF HYSTERO-EPILEPSY.—Dr. Mundé does not consider true epilepsy ever to call for the removal of the ovaries with a view to a cure of the disease. He would never remove the ovaries for dysmenorrhœa, neurasthenia, hemicrania, or any other neurotic affection, however closely it might seem to be connected with the menstrual function. The only rule he would suggest would be the unquestionable relation between the functions of menstruation and ovulation and the epileptiform convulsions, and the dependence of the latter condition on the former, and, further, upon the failure of any other form of treatment to effect a cure.—Dr. Paul F. Mundé in the *American Journal of Obstetrics*, April, 1892.

THE GALVANIC CURRENT AND THE CERVIX.—It is not only unnecessary but unwise to use a strong galvanic current to dilate the cervix. The negative pole should be employed. Ten or fifteen milliamperes at most is sufficient, and the application should never be continued longer than from three to five minutes.—*The Archives of Gynecology*, April, 1892.

PRINCIPLES OF THE TREATMENT OF UTERINE DISPLACEMENTS.—Dr. Banga advocates general treatment with no pessary and practically no local treatment in all but a few cases of uterine displacement. This is essentially the view held by many homœopaths, i.e., that remedies will effect a symptomatic cure though the uterus remains displaced and that local treatment is rarely necessary.—*American Journal of Obstetrics*, 1892.

ÆTIOLOGY OF ANTEFLEXION.—The chief ætiological factor of anteflexion is to be found in contractions of the utero-sacral ligaments. There are relatively few cases

of antelexion in which this contracture does not play an important part, a fact which accounts largely for sacralgia and retro-uterine tenderness as persistent symptoms in this deformity. Rest, pelvic depletion, and manipulations for the stretching of the ligaments should be practiced.—Dr. C. A. L. Reed in *American Journal of Obstetrics*, 1892.

SEROUS PELVIC PERITONITIS.—The administration of cathartics during the irritative stage is useless. The application of a large sound ice bag is preferable to warm applications. All patients can bear them if their use is insisted upon with sufficient energy. The effect of the cold is to diminish congestion, relieve the pain and reduce the temperature. It has a cooling effect to a certain depth.—J. Schmitt, M.D., in *American Journal of Obstetrics*, 1892.

ERGOT IN TREATMENT OF ABORTION.—In the treatment of abortions, Dr. Bonfield never administers ergot while the vagina is tamponed. Ergot acts most powerfully on the lower portion of the uterus, and thus imprisons rather than expels its contents.—*American Journal of Obstetrics*, 1892.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY,

CONDUCTED BY

CHAS. M. THOMAS, M.D.

OPHTHALMOLOGIC HINTS.—Dr. E. M. McPherson states that the following facts pertaining to ophthalmic practice are worthy of being remembered :

A vascular condition of the upper part of the cornea is almost positive evidence of existing granular conjunctivitis.

Chronic inflammation of the cornea of a child whose upper incisor teeth are dwarfed and deeply notched on the cutting edges is the result of inherited syphilis.

Errors of refraction, as myopia, hyperopia, and astigmatism, are usually congenital conditions, and can only be *corrected*, not cured.

The use of poultices is not only useless but positively harmful in most diseases of the eye.

Gradually increasing hardness of one or both globes, with pain and dilatation of the pupil, means glaucoma, and demands that an iridectomy be performed at the earliest possible time.

Two drams of boric acid to one pint of water is one of the best among the many eye-washes, and will, if used freely, be all the treatment necessary for most conjunctival inflammations.

Atropine is a dangerous drug to use in the eyes of elderly people, owing to its tendency to provoke glaucoma.—*Merck's Bulletin*, May, 1892.

PARENCHYMATOUS KERATITIS AND CORNEAL OPACITIES—THEIR TOPICAL TREATMENT WITH MERCURIAL OINTMENT.—J. Mitvalksy, M.D., Lecturer on Ophthalmiatrics at the Royal and Imperial Bohemian University of Prague, states that the local therapy of parenchymatous keratitis may have two different objects. First, it may strive to shorten the course of the disease, by aiming at hastening the process of inflammatory infiltration, and of the consequent vascularization which goes hand in hand with the absorption of the inflammatory products. As a means of attaining this object, we possess, principally, the lukewarm and warm lotions, which, by increasing the temperature of the part and occasioning an increased flow of blood to the same, are perfectly adapted to assisting us in our purpose.

Secondly, we may endeavor to effect a shortening of the duration of the disease by striving, with suitable remedies, to fix, as it were the disease in the present stage of its progressive development. The object of this therapy would be, therefore, to check the further course of the parenchymatous keratitis, and to effect the immediate absorption of the inflammatory products through the lymph current; and if the parenchymatous infiltration has already arrived at the stage of vascularization, the aim would be, not to favor the further development of these bloodvessels, but

to leave the remainder of the task of absorbing the inflammatory products likewise to the agency of the corneal lymph-current.

It is clear that only such drugs as are powerful sorbefacients and antiphlogistics at the same time, but which do not exert too irritating or alterative an effect on the corneal and conjunctival tissues could be of service to us in attaining our purpose. These same could, as in other cases, be employed either in fluid or ointment form, combined with massage.

After three years' careful probation of the remedy, it is asserted that blue ointment best meets the requirements above mentioned. The following formula is recommended :

Mercurial Ointment (33 per cent.),	1 part.
Vaselin,	2 parts.
Lanolin,	1 part.

Applied to the eye this ointment adheres nicely to the anterior membranes, so that not even the tears can wash it away; and by means of massage of the cornea, either with the tip of the finger direct, or, preferably, with the eyelids, we can ensure the steady absorption of the remedy.

The action of the mercurial ointment in the local treatment of parenchymatous inflammation of the cornea manifests itself differently according to the stage of the affection, and according to the way the case is otherwise constituted. It proves most efficacious, in the majority of cases, in the very first stages of infiltration. In these cases we attain with the mercurial ointment a comparatively prompt absorption of the inflammatory products in most cases, without a typical stage of vascular formation fully developing; the vessels either do not appear, or they show themselves in restricted numbers. Where pericorneal injection is markedly developed, especially if there is photophobia and brow-ache, the ointment is absolutely unsuitable, because the latter symptoms are invariably aggravated, and the eventual sorbefacient action of the remedy cannot sufficiently compensate us for the danger of an iritis or irido-cyclitis.

The duration of the cases suitable for the mercurial treatment often is shortened one-half, or at least one-third, so that very frequently after but 3 to 4 weeks' treatment, the patient may be discharged. This local treatment in no way prejudices the general treatment, nor the careful treatment with atropine, and 1 per cent. of atropine may be mixed with the ointment.

The mercurial ointment may also be used for clearing up corneal opacities of any kind.—*Merck's Bulletin*, May, 1892.

SEAT OF CENTRE FOR WORD-HEARING.—Dr. Charles K. Mills, of Philadelphia, locates the centre for word-hearing in the hinder two-thirds of the first and second temporal convolutions. Its exact position is in a line with or just in front of the posterior extremity of the horizontal branch of the fissure of Sylvius. Possibly it is restricted to the second convolution. Almost complete word-deafness will follow a lesion confined to the posterior thirds of the first and second convolution of the left hemisphere. The field for auditory memories covers the posterior two-thirds of the first and second temporal convolutions. The auditory field and special auditory centres have their highest development in the left hemisphere.—*University Medical Magazine*.

RAT-TAIL SUTURES.—Dr. A. M. Belt (*Medical News*) says that for some years he has been using rat-tail sutures in eye surgery. They are finer than any other animal sutures; sufficiently strong, easily kept aseptic, and, as they become pleasantly soft when moistened, are unirritating, and never have to be removed.

MASSAGE OF THE MUCOUS MEMBRANE AND ITS CURATIVE RESULTS IN CHRONIC DISEASES OF THE NOSE, THROAT, EAR, AND LARYNX.—Before resorting to this method of treatment, so enthusiastically advocated by Carl Laker, a thorough investigation of the topography of the nasal cavities or other part to be treated must be made. The massage must then be carried on without the aid of sight, guided only by the sense of touch and the mental picture of the topography. The instrument preferred by the author is a sound of packfong, twenty-two centimetres long, diameter six to seven Charrière. The end of the sound is knobbed,

and to it is fitted exactly the wad of cotton. The end is dipped into a 10 per cent. solution of cocaine or smeared with pure vaseline or menthol vaseline; it seems to be of little importance which remedy is used. The probe is grasped like a pen in the right hand, introduced into the nose; then, the forearm being flexed, the muscles of the arm contracted; regular vibrations of the forearm are set free and transmitted through the sound to the mucous membrane. The vibrations must be as regular as possible, an irregular vibration being very painful. This regularity can be acquired only by practice. Analysis has shown that the number of vibrations lie between six hundred and two thousand per minute, and can be made with such regularity that the difference in time between any two vibrations scarcely reaches one one-hundredth of a second. The vibrations in laryngeal massage lie between five hundred and six hundred a minute.

The sensation is unpleasant, sometimes painful, to the patient, the more so the more acute the condition. Treatment must not be too harsh at first, especially on the middle turbinated body and the upper part of the nose. On the other hand, superficial massage lengthens greatly the treatment. Hemorrhage during massage is frequent, but has never done any harm. The duration of each sitting is from several seconds to several minutes, according to the sensitiveness of the patient. The average length of treatment is from three to six weeks, sometimes much longer, although in such cases a steady improvement keeps the patient from becoming discouraged. It is too early to say how long cures will last, but the author knows many patients free from troublesome symptoms for a year after treatment was completed.

The treatment is applicable in most nasal affections, hypertrophic conditions being more amenable to treatment than atrophic; indeed, in cases where the breathing space is diminished this treatment finds its greatest triumph. In most cases five days elapse before there is any evident improvement. Pathological reflexes, as headache, cough, neuralgia, asthma, etc., disappear. Membranous adhesions between the septum and a turbinated body atrophy under this treatment. Some hypertrophies, however, have still to be treated by the snare. The author also claims that the site of polypi can often be changed into healthy tissue. Light grades of atrophic rhinitis improve wonderfully. In these cases the first nasal space must also be treated, and in more advanced cases the pharynx and larynx. In the frequent sore throats of children massage is valuable. The author speaks very favorably of its use in middle-ear troubles.

By its use in the larynx, long-standing deficiencies of the muscles of the vocal cords disappear. Ulcerations of the larynx can be cured, and even tubercular ulcers have been healed.

The technique of laryngeal massage is more difficult than of the naso-pharynx, and is unpleasant but not necessarily painful. The length of laryngeal massage is naturally very short, as respiration ceases during its progress.

In secondary chronic conjunctivitis, nasal massage is valuable.—*Prager Med. Wochenschrift*, February, 1892.

DISEASES OF THE BRAIN AFTER SIMPLE NOSE OPERATIONS.—Dr. Wagner finds only three such cases in literature, in all of which the middle turbinated body was the part operated upon. In the author's case the lower and middle turbinated bodies were cauterized with the galvano-cautery (the middle one on its lower border). On the third day there were two violent hæmorrhages, for the second of which the nose was tamponed. On the next day the temperature rose. The tampons were removed without effect on the temperature. Later, symptoms of meningitis appeared, and death soon followed. The blood in the hæmorrhages came not from the cautery wound, but from the upper and back part of the nose. It was venous in character. Thrombosis had probably taken place in the longitudinal sinus, causing stasis and venous bleeding from the nose. There was no autopsy.

The middle turbinated body is the dangerous field. We cannot perfectly disinfect the nose, and it is not in our power, by any precautionary measures, to prevent such a catastrophe as this.—*International Medical Magazine*, March, 1892.

ZINCUM SULPHURICUM is of service in the treatment of opacities of the cornea, following repeated and long-lasting attacks of inflammation of the membrane.

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,

FRANK H. PRITCHARD, M.D., AND E. M. HOWARD, M.D.

TREATMENT OF CHRONIC ENDOCARDITIS.—Dr. P. Jousset, of Paris, like Prof. Huchard, divides chronic endocarditis into two classes: vascular cardiopathies and valvular cardiopathies. Vascular cardiopathies are dependent upon arterio-sclerosis, are found in syphilitic patients, alcoholics, malarial patients, but principally among gouty subjects and their descendants. This form of disease, consists essentially of arteritis of the coronary arteries, followed necessarily by an alteration of the muscular fibres of the heart muscle or, properly speaking, a myocarditis.

Treatment of Vascular Cardiopathies.—The treatment is divided into that of the diseases and that of the complications, the principal one being asystolia, while the others correspond to the emphysematous, painful, arhythmic, tachycardic and brachycardic varieties of the disease. The treatment of the disease is divided into the hygienic measures and the medicinal treatments. Indeed, the treatment of the disease is the treatment of the arterio-sclerosis.

Hygienic Treatment.—The abuse of alcohol and meat are principal factors in the production of arterio-sclerosis. The excessive use of tobacco predisposes but does not act directly upon the arterial tissues. It, however, causes cardiac neuralgias and diminishes the contractile force of the heart. The habitual use of milk and living in the open air counteract advantageously the action of arterio-sclerosis.

The principal drugs in the treatment of this disease are: *Glonoine, spongia, the iodides, arsenicum and plumbum.*

Iodide of Potash.—The iodides of potash and soda have both been praised in the treatment of arterio-sclerosis, and consequently in that of vascular cardiopathies. These two drugs, like all remedies, have two opposed actions; they first augment the vascular tension and then, secondarily, diminish it. This primary action is obtained by small doses, the secondary by large doses. The writer habitually employs the first decimal trituration of the iodide of sodium. If this is inefficacious then he gives it in doses of 5, 10 or 25 centigrammes. Experience has demonstrated that it is necessary to increase the doses to 1, 2 and 3 grammes *per diem*, as in syphilis. This treatment should be continued for months or even years.

Glonoine.—The physiological action of glonoine is remarkable, for a few drops or even olfaction of the 1-100 solution produces almost instantly heat and redness of the face, a pressive headache, violent palpitation of the heart, a hard and frequent pulse, which bounds and may be perceived even to the tips of the fingers. If the dose be increased the pulse slows, becomes intermittent and finishes by becoming scarcely perceptible. Dr. Piedvache has demonstrated that 10 to 20 drops of the 1-100 solution increases the vascular tension. This remedy also produces substernal lancinating pains, with a sensation of weakness and numbness in the left arm, dyspnoea with a sensation of constriction in the chest, anxiety, etc. This drug, under the name of trinitrin, has been used with success by Drs. Murrel and Huchard. It is indicated during the attack, in angina pectoris and in vascular cardiopathies, to relieve the dyspnoea. Simple olfaction of a 1-100 solution is ordinarily employed in the treatment of angina pectoris and during the violent dyspnoeic attacks which often accompany vascular cardiopathies. If one desire to combat the disease itself, and especially the augmentation of arterial tension by the homœopathic action of this drug one then may give daily doses of 5, 10, 15 and 20 drops of the first dilution to be taken in four doses a day.

Arseniate of Antimony.—Arsenic and antimony are two cardiac remedies. The former includes in its pathogenesis, amongst other symptoms, dyspnoea, an irregu-

lar, small and imperceptible pulse, anxiety and nocturnal agitation, and, by its long-continued use, it produces anasarca and the cardiac cachexia. Nothnagel and Rossbach state that it produces an enormous lowering of the blood-pressure if given in large doses. [The experiments of Vrijens, made under the direction of Stokvis, of Amsterdam, Holland, demonstrate that intravenous injections of sol. Fowleri cause gradual sinking of the blood-pressure, with periodic rises above the normal, of short duration, with irregular and very slow pulse. Small doses, frequently repeated, increase the pulse rate, with following slowing. The slowing of the pulse is but slight in the first period of poisoning and extraordinarily pronounced in the second. In most acute cases of poisoning the sinking of the blood-pressure is uninterrupted, together with that of the pulse from the beginning.—Alfred M. Vrijens, *Onderzoekingen over Intraveneuse Arsenik-Intoxicatie*, inaugural dissertation, Amsterdam.—Eds.] Tartar emetic is a direct poison to the heart, and, after having increased the force and number of contractions of the cardiac muscle, it determines a paralysis and weakening of this organ. The arseniate of antimony is a preparation which the writer employs habitually. It has given him good results in incipient vascular cardiopathies. It is especially indicated in dyspnea from effort, which it rapidly modifies.

Spongia has been employed by some homœopaths in the treatment of some heart affections. The composition of this medicament approaches that of the iodides.

Plumbum.—This is a remedy which corresponds, from a pathogenic point of view, to the symptoms and lesions of arterio-sclerosis, but like in *spongia*, clinical experience has failed to fix the indications sufficiently. [See Bruckner, *Spongia Bei Herzkrankheiten*, *Archiv für Homœopathie*, Nos. 6-7, 1892, translated by Bruckner from Hering's *Homœopathic Clinics*. With regard to the use of plumbum in arterio-sclerosis, one may refer to the note of Dr. Gatchell in his *Keynotes on Medical Practice*, ed. 1887, p. 67.—Eds.]

Treatment of the Complications of Vascular Cardiopathies; Treatment of the Asystolia.—The remedies indicated in the treatment of asystolia are: *Digitalis*, *convallaria majalis* and *sparteine*.

Digitalis.—This remedy is one of the most powerful in this complication. In a moderately large and a powerful dose it produces a true asystolia. From this the writer concludes that the therapeutic action of digitalis in asystolia is based on the law of similars, and that in this affection one must administer moderately large or large doses, as these only produce asystolia. Up to within a few years the maceration of the leaves of the drug has seemed to the writer to be the best means of administering the drug, yet at present he employs the chloroformic digitaline, i.e., that soluble in chloroform. This is more certain and energetic in its action. It is known in Germany under the name of digitoxine. The other forms of digitaline, soluble in water and insoluble in chloroform, cannot be compared with this. Mialhe prepares a solution of this 1-1000, which represents the third decimal dilution of which 60 drops represent 1 milligramme ($\frac{1}{84}$ gramme) of digitaline. Thirty drops of this are a dose of sufficient power. When the asystolia is very pronounced and a rapid action is desired 60 drops of this solution may be prescribed taken twice a day. Diuresis sets in at the end of twelve hours, at all events before twenty-four hours. The urine becomes clear and reaches 3 to 4 liters in quantity. At the same time the pulse becomes regular and strong, the dyspnea diminishes and the dropsy disappears. This dose may occasion nausea but never vomiting. The effects of this single dose persist for several days. In accidental asystolia it suffices to cure the attack, but in habitual asystolia, when the effect has worn off, say in eight to fifteen days, the medicine must be repeated. When the symptoms are less urgent a dose of 30 to 40 drops will be all that is required, but it will be a few hours later than from the dose of 60 drops. But, in habitual asystolia, the author has obtained good results from the administration of small doses of digitaline, 5, 10, 15 drops per diem. With these doses the diuretic action did not begin until the third in some cases, and never did it attain the proportions of 3 to 4 liters in twenty-four hours, as with the larger doses. But by repeating the small doses every two or three days a continuous diuretic action is obtained with consequent amelioration of the cardiac functions, which seem to be greater and more lasting than from the use of larger doses at longer intervals.

Convallaria Majalis.—This drug is a substitute for digitalis, but its physiological action is so incomplete that one is unable to fix the indications. Clinical experience teaches that it increases the force of the heart-beat and regulates the heart's action in those patients who present weakness of the heart muscle and irregular

pulse. Its diuretic action is analogous to that of digitalis. In large doses it is a drastic purge. The writer prescribes it when digitalis fails him, *i.e.*, hardly ever. The two active principles of convallaria, convallarine and convallamarine, being very soluble in alcohol he prescribes it in the mother tincture, 5, 10, 20 drops progressively given.

Sparteine.—This is the alkaloid of the broom. That which was said of convallaria holds good of this also. It acts very rapidly and the sphygmograph records a change in the pulse a quarter of an hour after its administration. Its action is also lasting, and persists for three or four days. It does not disturb the digestive functions like digitalis. It is said not to be diuretic (?), but the author doubts this. [Prof. Levascheff states that it is a diuretic, not by direct action upon the renal epithelium like calomel, for example, but by increasing the blood-pressure. Hale, *Diseases of the Heart*, 1889, p. 287.—Eds.]

Strophanthus.—This is a plant of the Apocynaceæ family, which grows upon the east coast of Africa, and is a heart poison. If one say that it is an analogue of digitalis, that it increases the force of the cardiac contractions and of the arterial pressure, that it is diuretic, then all the known indications will be given. One should employ it, like the lily of the valley, when digitalis fails. The writer has used it in vascular cardiopathies characterized by arrhythmia, but not when there was a true asystolia. Ten to twenty drops of the mother tincture may be given daily.

Caffeine.—This alkaloid is found in tea, green coffee, guarana, the kola nut, Paraguay tea, etc. Prof. Huchard regards it as a tonic of the heart and arterial system, for, if administered in a large dose to patients suffering from considerable weakness of the heart muscle, with great diminution of the arterial tension it increases the tension and re-establishes the energy of the cardiac muscle. But, the author had demonstrated that, if, in small doses, caffeine increases the force of the heart-muscle and augments the arterial tension, in warm blooded animals, then, in the doses employed by Prof. Huchard, it would paralyze the heart and diminish the arterial tension. The action of this remedy is therefore homœopathic to the treatment of asystolia, being another analogue of digitalis. The writer prescribes it in those cases where the weakness of the cardiac muscle is excessive, the pulse extremely weak and the heart sounds are greatly diminished and when the state of syncope is almost permanent, whether the pulse be irregular or accelerated or not. As the larger doses are those which produce enfeebling of the heart muscle, therefore they are the ones which should be given in cases of cardiac paresis. The writer ordinarily prescribes the first decimal trituration of the drug, 25 cgms. to a gram. Prof. Huchard employs much larger doses, injecting hypodermatically up to 40 cgms. In cases where the danger is very great he repeats the injection every three hours. The author has obtained good results from a single injection of caffeine: four injections in twenty-four hours seem a limit which scarcely need be passed. Indeed, when the remedy will not act in these doses it is useless to continue it, as the writer has observed several times.

Ergotine.—The writer regards ergotine much the same as he does caffeine. If a small or moderate dose of ergotine increases the artificial tension, especially in the peripheral arteries, then a large dose accelerates the pulse and diminishes the arterial pressure. Now, the injections of Prof. Huchard are large doses and consequently their action is homœopathic. Theoretically ergotine is indicated in cases where the arterial pressure is excessively feeble. Tanret's ergotine is advised to be given hypodermatically, in doses of 4 drops.—*L'Art Medical*, No. 4, 1892.

TREATMENT OF CHRONIC VALVULAR HEART DISEASES.—Dr. P. Jousset, of Paris, in the treatment of chronic valvular heart diseases, has the patient avoid all fatigue or excess and especially to be on guard against a return of the acute endocarditis, to which the affection owes its origin. *Aconite* at the beginning, especially if there be a distinct febrile movement present. *Cactus* when the patient experiences a cramplike pain in the region of the heart, with irregularity of the pulse. *Spigelia* when the endocarditis is accompanied by more or less distinct signs of angina pectoris. To these remedies one may add digitaline and helleborus niger, the good effects of the latter being especially manifest to us in recent use.

Digitaline.—This preparation is the chloroformic digitaline, the digitoxine of the Germans, which the writer prefers to all other preparations of the drug. He has observed several cases where Mialhe's digitaline, in solution, 30 to 50 drops, very rapidly removed the asystolia for which it was administered. This is well known, yet if one continue the administration of small doses of digitaline, 5 to 10

drops every two to three days, in valvular cardiopathies the heart will become more and more regular, the dyspnoea will diminish, the souffles and murmurs grow less intense, and, finally, the general health of the patient becomes established to a degree which could be scarcely hoped for.

Helleborus Niger.—This drug has given the writer results analogous to those obtained from digitaline. This will be found nothing surprising if one remembers that the root of *helleborus niger* contains two glucosides, helleboreine and helleborine. The former is a violent heart poison, the effects of which upon the skin, mucous membrane and heart resemble those of digitoxine entirely. The experiments of Pecholier have shown the pulse to be very rapid, while death takes place with the heart in systole. Tradition teaches but very little of the use of helleborus in the treatment of heart diseases. Bacher's pills, which contained hellebore were praised in dropsy and were sometimes used, with success, in the treatment of heart diseases.—*L'Art Medical*.

THE THERAPEUTICS OF STRYCHNINE.—Dr. T. D. Nicholson, in an able study of the therapeutics of strychnine, reviews the principal symptoms of the drug, and their therapeutic relations.

Mind.—*Delirium resembling mania-a-potu, low spirits and depression, nervousness and anxiety, restlessness*. The drug has proven very useful in delirium tremens. Provings further simulate both the nervous agitation of the insane, and fidgets of hysteria. The author has used strychnine successfully for the marked restlessness and anxiety after a severe attack of asthma.

Head.—*Confusion, vertigo and nausea, violent pains especially occiput and frons, bursting headache morning, and on stooping*. When these symptoms are connected with the stomach, *nux vomica* is well indicated; when spinal, strychnia is to be preferred.

Face.—*Flushing, lividity, becoming pale, ulcers of the lips*. The last symptom is especially an indication for this drug when accompanied by weakness of long continuance.

Throat.—*Spasm, constriction, dysphagia*. Where these are hysterical, they are best treated by either strychnine or *ignatia*.

Stomach.—*Nausea, vomiting, intense pain in the epigastrium*. Anstie recommends the drug for cardialgia, and Phillips extols it in gastralgia and hepatalgia.

Abdomen.—*Flatulence, bruised sensation, griping pain, sharp pain, rectum and anus*. When the pains are severe and neuralgic, strychnine meets them better than *nux vomica*. There is a strong consensus of opinion that strychnine is of great service in prolapsus ani or recti.

Urine.—*Urging, frequent urination, involuntary after 15 gr. quantity scanty or copious*. Strychnine has been found of great service in paralysis of the bladder and for incontinence and retention in old people.

Respiration.—*Irregular, intermittent, difficult. Respiration rapid, with great pain in precordia*. Strychnine is invaluable in the dyspnoea of chlorosis. Some cases of catarrhal asthma are terminated by a few doses, and most cases of long standing are benefited by its administration. In a case of chronic phthisis with severe dyspnoea, exhaustion, and great anxiety, gradually increasing for several days, and in which a fatal result was imminent, the steady administration of the drug for some weeks quite controlled the symptoms, and the patient regained her usual condition of health.

Heart.—*Palpitation, rapid pulse, 115 to 150, nearly pulseless*. In cardiac weakness with feeble pulse there is no remedy equal to strychnine.

Neck and back.—*Aching in nape. Stiff back. Sore muscles of spine. Lumbar pains*.

Sleep.—*Restless and disturbed*. In cases of exhaustion with disturbed sleep, strychnine is very efficacious.

Extremities.—*Twitching and stiffness of hands, jerking rheumatic pains. Loss of power in legs after three-quarters of a grain. Loss of use of legs after three and a quarter grains. Cramp-like pains*. The use of strychnine in paralysis has suffered from over-praise and neglect. We may expect good results from it in all functional paralysis, where of muscle or hollow viscera, in hysteria and diphtheria, but in nerve lesions it is of doubtful utility.

Fever.—*Heat is a frequent symptom of strychnine and the temperature is raised after large doses. It is preceded by chill and followed by sweating*.—*Monthly Homœopathic Review*, June, 1892.

ASCLEPIAS TUBEROSA.—Under the head of neglected remedies, Dr. Wm. E. Leonard refers to *asclepias*. But one proving of the drug is found in the *Encyclopædia of Drug Pathogenesis*, that of the late Dr. Thos. Nichol, of Montreal.

In Dr. N.'s proving, his first sensations pointed to the respiratory tract, viz., dry, hacking cough, with constriction of the throat, a feeling of warmth in the chest, also tightness; later the breathing became painful, especially at base of left lung; there were sharp pains shooting from the left nipple downward, with stiffness of left side of neck. Accompanying this was a pain in the forehead and vertex, and finally as of pressure deep on the base of the skull, worse from motion, and relieved by lying down. The chest pain settled behind the sternum, and became more sharp and cutting, being worse from a long breath or moving the arm; the spaces between the ribs, close to the sternum became sensitive to pressure; chest pains were relieved by bending forward. Dr. N. even records a dulness upon percussion of the lower left lung.

The similarity of this picture to that caused and cured by *aconite*, and more closely, *bryonia*, is evident. As far as the provings go, although Dr. N.'s pains later in the proving, shifted to the right side, *asclepias* would seem to be indicated in the left-sided pleuro-pneumonia, as *bryonia* is more commonly in the right side.

The gastric symptoms of the drug are not reliable, because the only proving having any, was subject to some gastric irritation; but a soft, fetid stool, preceded by rumbling, was the (to him) unusual accompaniment in Dr. N.'s proving. The latter prover felt at the end of five days as though recovering from a long and severe illness, although he had few of the rheumatoid muscular and articular pains of other provers. In one case related by Dr. H. N. Martin (*N. A. J. of Hom'y*, 1870), *asclepias* relieved a long-standing pain over the fundus of the bladder and lower abdomen, with constant loose stools for years, aggravated by the excessive use of tobacco. The relief was prompt and complete as long as he abstained from tobacco. In these days of narcotic antidotes, *asclepias* may yet take rank with *arsen.*, *ipee*, *plantago*, *conium*, etc., against tobacco.—*Northwestern Journal of Homœopathy*, June, 1892.

THE PHYSIOLOGICAL ACTION AND THERAPEUTIC USES OF HYPERICUM PER-FOLIATUM.—In a lecture on this subject, Dr. A. C. Pope says, referring to the symptoms of hypericum, that they one and all point to the induction of a general state of hyperæsthesia, followed by an hysterical condition. Under the influence of hypericum the head feels confused and excited; a throbbing hammer-like pain and pressure over the crown of the head, with tearing and stitches in the temples; one curious symptom mentioned is a feeling as though there was "something alive" in the brain. By each prover pains in the nape of the neck and a sense of pressure or burning over the sacrum are mentioned. It is chiefly in the extremities and in the pectoral muscles that we meet with the development of hyperæsthesia which is so characteristic of the drug. Thus we have—darting pains in the shoulders, burning in the pectoral muscles, cramp, tearing and tension in the arms, pressure along the ulnar side of the forearm, jerking in the tendons of the wrist, tension in the legs, cramp in the calves of legs and feet, cold feet, "furry feet," tingling in the legs and feet, drawing pains in the lines of the nerves of the legs, with coldness and numbness. With all this is associated a miserable dejected melancholy feeling, and a tendency to weep; the memory becomes defective, and there is incapacity for any employment; while in one instance there was a craving for wine. Sleep during a proving was nearly uniformly restless and full of dreams of an exciting and horrible character. Digestion is more or less disturbed, and the tongue furred, the appetite diminished, the epigastric and umbilical regions disturbed with flatulence, and the stools alternately costive and relaxed.

The excessive irritation and hyper-sensitiveness of the nerve tracts and the general nervous depression, have led to the generalization that hypericum is indicated as a remedy in disorders which are the sequelæ of injury to one of the nervous centres. Thus Dr. Ludlam has reported two cases cured by this drug, one of asthma, and the other of spinal irritation, based on this indication.

Hypericum has also been used with success in the treatment of lacerated wounds, and wounds of tissues rich in nerves. Dr. Franklin has also found it invaluable in painful open wounds attended with great prostration from loss of blood; and Dr. Helmuth finds it superior to morphia for pain after operations.

Two or three drops of the second dilution has been the dose which is usually prescribed.—*Monthly Homœopathic Review*, May, 1892.

TARAXACUM IN DIABETES.—Hahnemann was in the habit of prescribing this drug in the treatment of diabetes, a few drops of the pure tincture being given several times a day. Formerly this plant was highly thought of in the treatment of diabetes, yet recently it has been abandoned for foreign drugs, and without just cause. There is a proving of this drug by Hahnemann and his pupils, in which symptoms which accompany this affection are developed. It is, apparently, a remedy suitable in diseases of the liver and pancreas, when these organs are accompanied by stasis in the portal region. As it has recently been proven that diabetes is connected with affections of the pancreas, for, in persons who have died from diabetes this organ is found atrophic, one might do well to keep this drug in mind in the treatment of this affection.—*Leipziger Populäre Zeitschrift für Homöopathie*, No. 3-4, 1892.

ACONITE IN SUDDEN BLINDNESS FROM COLDS.—Dr. H. Goullon, of Weimar, Germany, cites the case of Mr. S., a bookseller, strong, always well, and unmarried, thirty years of age, who, in April, one evening took his frugal meal at a restaurant, after which he soon went home and retired. He read some time in bed until he was overcome with sleep. After sleeping the entire night he awoke at the accustomed hour apparently well; finding it still dark he tried to go to sleep again but was unable to do so. He lit two or three matches, in order to see his watch, but without success. In trying to light the fourth the head fell off and burnt his hand, when he felt a violent pain, without being able to see the burnt hand or a trace of the sparks, when the horrible thought dawned upon him that his sight was gone. He called the servants and found this certain, fell into a desperate condition, cried out, wept bitterly, wrung his hands, and, finally, sent some one after a physician post-haste. On examination, no objective symptom could be discovered. The pupils were only slightly dilated. No ophthalmoscopic examination was made. The only cause which could be made out was that the restaurant where the patient took his supper had been suffocatingly hot, full of smoke, and that he had gone home in very wet and stormy weather. Therefore a cold, with consequent functional disturbance of the optic nerve was diagnosed. The patient was put to bed at once and *aconite* 3x, a few drops in a glass of water, and two teaspoonfuls every hour were given. A cup of beef tea was taken several times during the day. At the evening visit no change was found, but the patient was in a profuse sweat. Improvement was promised for the next day. The morning visit found him in full possession of his vision. He had slept well the whole night and perspired profusely. That noon he arose from his bed, keeping the room that day, and the following day he was able to attend to his business. A second and similar one, given in support of the first, was that of a physician, who while taking a bath in the river, had scarcely been two or three minutes in the water, when he noticed, to his horror, that his sight was rapidly disappearing, until after a few seconds it was entirely gone. He left the river and, after carefully rubbing himself dry he proceeded home assisted by a friend. Though it was bright daylight he did not see a trace of it, for all was as dark as night to him. On reaching his home he went to bed, wrapped himself well up in the bedclothes and took *aconite* 3x every hour. After two hours he began to perspire profusely, after which he fell into a quiet sleep, which lasted for six hours. On awakening he was dripping with sweat. The event just passed seemed like a dream—his sight was restored. The blindness is ascribed by the writer to a congestion of the retina, with resultant disturbances of the retinal capillaries, with consequent inhibition of the visual function. The *aconite* was prescribed on account of the cold alone. The writer recalls a case of poisoning by *aconite* in a child where transient blindness was remarked. (A maid servant took a mouthful of the tincture of the root. The usual violent symptoms followed, with extreme dimness of vision and staring eyes. Restoratives were given, after the administration of an emetic. Sight then improved and she said that she felt like one coming from a narrow dark, hot room into a well lighted one.—*Lancet*, ii., 13; *Cyclopaedia of Drug Pathogenesis*, vol. i., page 3. A man, aged thirty-five, took 40 grammes of the tincture of *aconite*, consciousness intact, but he is quite blind.—*Gazette Médicale de Paris*, January, 5, 1844, p. 12. A young lady had *aconite* tincture painted on her spine for spinal irritation. Pupils widely dilated, vision greatly impaired. She could not read ordinary print. Ophthalmoscope showed the *arteria centralis retinae* to be dilated, and retina congested.—*Practitioner*, xi., 21. *Matthiolus* gave a man, aged twenty-seven, one drachm of *aconite*. Violent symptoms supervened. He three times lost his sight.—*Matthiolus*, *Comm. in Dioscor.*, cap. 73, 1561; *Cyclo-*

podia of Drug Pathogenesis, vol. i., page 113. Dr. Fleming, the learned English veterinarian, says: when aconite is introduced into the system of one of the lower animals, it produces weakness of the lower limbs and staggering. The paralysis increases, etc. Blindness, to a greater or less extent, soon supervenes, etc.—*Encyclopædia*, p. i., page 116.)—Eds.

TREATMENT OF NEURASTHENIA.—Dr. Donner, in a lecture before the Hahnemannian Society of Wurtemberg, Germany, played on the treatment of neurasthenia, placed *argentum nitricum* in the first rank. Then comes *platina* when the disease is due to overwork; it is especially indicated in female patients and hysterics. *Phosphoric acid* and *ignatia* are also often indicated, the latter in women. *Nux vomica* and *natrum muriaticum* are especially indicated in the digestive disturbances of neurasthenic patients. The latter is also of value in a multitude of other nervous diseases. As neurasthenia is nearly always combined with chlorosis or anæmia, the ferrous preparations are of service, given of course in the homœopathic forms; for example, *ferrum phosphoricum*, *ferrum citricum*, *ferrum oxydatum rubrum*, etc.—*Homœopathische Blætter*, No. 5, 1892.

INFLUENZA.—An anonymous correspondent of the journal, *Homœopathische Blætter*, No. 4, 1892, employed *argentic nitrate* in influenza, with success. The fever of the grippe he has found to yield better to *natrum nitricum* than aconite. The eye symptoms are removed by *euphrasia*. Another correspondent used *natrum sulphuricum* with good results in the treatment of this disease.

FISTULA IN ANO CURED BY SULPHUR.—Dr. DeWee, communicated, at a session of the Association of Belgian Homœopathic Physicians, the case of a young man who before, for three years had suffered from eruptions. The next year he was seized with a pain in his rectum to be followed by the appearance of a fistula in ano. Walking was impossible. He underwent several operations yet with indifferent results. In 1891 a second fistula formed on the other side of the anus. The canal was indurated and stool very painful, although he was not constipated. With regard to the psoric constitution of the patient the writer prescribed *sulphur* 30, to be taken for 14 days. After 8 days the discharge had ceased to a great extent and the pains disappeared. After sometime he administered *sulphur* 6x, a knife-pointful to be taken every day. The patient took this for 14 days and was then able to go hunting, without any particular fatigue. This remedy was continued and now, two and a half months after beginning treatment, he is completely cured.—*Revue Homœopathique Belge-Homœopathische Monatsblætter*, No. 4, 1892.

GRAPHITES IN MARGINAL BLEPHARITIS.—H. Kesselring, a layman, used graphites with the best results in a case of blepharitis marginalis. It was administered, at first in the 6th, then in the 12th, and finally in the 30th decimal trituration, for two days each, and followed by intervals of six days each.—*Homœopathische Monatsblætter*, No. 4, 1892.

BISMUTH IN GASTRALGIA.—Dr. Goullon records the case of an aged person who took arsenic in order to relieve an attack of gastralgia, yet without success. *Bismuth nitrate* in the sixth trituration, was taken and it vanished. The characteristics of bismuth, in gastralgia are: the pain is violent and pressive, as if a weight were in the stomach, accompanied by profuse collection of saliva in the mouth. This latter symptom is very characteristic of the remedy. The pain of arsenic is, on the contrary, burning. Pain in the spine is a symptom indicating bismuth, which was present in this case. This usually sets in at ten o'clock in the morning. The father of this patient had died of cancer of the stomach, yet as this patient's stomach was not sensitive to pressure and there was no vomiting that was excluded.—*Leipaiger Populære Zeitschrift für Homœopathie*, No. 3, 4.

MENTHOL WITH AMMONIUM CARBONATE is recommended in *hay fever* by Dr. L. Wainwright as being more efficacious than simple MENTHOL. It is used from an ordinary smelling bottle, like other smelling salts.

EUCALYPTUS OIL, mixed with *petrolatum*, 1:16, is recommended by Dr. L. Browne as an application to the nostrils in *dry nasal catarrh*.

THE HAHNEMANNIAN MONTHLY.

AUGUST, 1892.

THE HISTORY, SYNTHETIC SYMPTOMATOLOGY, THERAPEUTIC APPLICATION, AND COMPARISON OF ANALOGUES OF
THUJA OCCIDENTALIS.

BY THE MEDICAL INVESTIGATION CLUB OF BALTIMORE, MD.

At the last annual meeting of this Institute, the Medical Investigation Club of Baltimore presented a paper descriptive of the character of work in which it has been engaged for some years past. In that paper reference is made to the necessities of a reconstruction of the homœopathic symptomatology, a description of the details of the plan adopted for accomplishing this end, and a brief mention of the various publications in illustration of this work; but we submitted to the Institute no concrete example of a symptomatology constructed in accordance with the synthetic method of the Club. In consequence of this unavoidable omission (because of lack of time and space), we this year desire to present for your consideration a drug treated according to our method. For such purpose we have, therefore, selected *thuja occidentalis*.

This drug is a sample of the work we have done, and more, it illustrates the character of work necessary to be done in the future to make the symptomatology of our school intelligible, practical, and scientific. As we described last year, the arrangement of departments in the accepted method of reconstruction consists in the history of the drug, a consideration of the sources from whence its symptomatology is drawn, its general sphere of action, its synthe-

tized symptomatology, and its therapeutic application. To this we now add a comparison of pathogenetic analogues.

Although a minute knowledge of the individual symptomatology of drugs may be necessary to the active practitioner, yet the surest way to familiarize one's self with such details is through a comparative study of those drugs whose action is more or less similar. The mind of man is so constructed that it remembers better comparative facts, associated facts, than it does isolated facts; therefore, the plan of study of homœopathic symptomatology should not be made an exception to this comparative method of reasoning.

Comparative symptomatology, then, is the symptomatology of the future, based, as it must be, upon pure pathogenetic work. To preserve this character of comparative details, it is necessary to exclude all material which is not strictly pathogenetic, even from the analogues under examination which have been introduced in comparison with the given drug to be studied. In this examination of the analogues of *Thuja*, therefore, only the pathogenetic effects of the drugs considered have been introduced. While we acknowledge the value of clinical observations in their proper field, it is obvious that they are out of place in this kind of work, and must be ignored. As a result of this critical work, we here submit the first pathogenetic symptomatology of a drug ever presented to the medical profession in connection with its complement of pathogenetic analogues.

HISTORY.

Thuja belongs to the natural order *coniferæ*, sub-order *cupressineæ*.

Synonyms.—*Thuja occidentalis* (Linn.), *cedrus lycea* (Ger.).

Common names.—American *arbor vitæ*; western *arbor vitæ*; tree of life; white cedar (true white cedar is *cupressus thyoides*) (Linn.); hackmatack (true hackmatack is *larix Americana*) (Mich'x); Fr., *Thuja du Canada*; Ger., *lebensbaum*.

The name is derived from the Greek *θυια*, *θυα*, or *θυια*, from *θυειν*, (Fr., *suffre*), to fumigate, indicating a resinous tree.

It is an evergreen, presenting a cone-shaped outline, attaining a height of twenty to thirty feet, and is a valued ornamental tree. It is straight, with recurved branches, yielding a pungent aromatic oil. The wood is light, soft, but exceedingly durable. It has very flat 2-ranked spray, on which the small leaves are closely imbricated. These are of two kinds, on different or successive branch-

lets; the one awl-shaped, the other scale-like, blunt, sharp, adnate. Scales of cones pointless; seeds winged all around.

It grows in swamps and on cool rocky banks, from New England to Pennsylvania and Wisconsin, chiefly northward, where it forms extensive cedar swamps, so-called, and is known as white cedar; rarely southward along the Alleghanies.

It blossoms from May to June, and matures its fruit in autumn.

There are four other species of this genus not in cultivation: Chinese thuja orientalis, Javanese thuja dolorata, thuja articulata of Barbary, and thuja cupressoides of the Cape of Good Hope.

Its therapeutic use previous to Hahnemann's day consisted in the treatment of rheumatism locally; in the form of decoction for coughs, fevers, scurvy, gout, and dropsy; and as a tincture applied to venereal warts.

A pathogenesis of thuja was first published by Hahnemann.

Proving's confirming the above were made by the Austrian Society, in which as many as 1000 drops of the tincture were used.

The tincture is prepared from the fresh branchlets, leaves and flowers. It has a deep orange-brown color by transmitted light, the odor of the bruised leaves, a bitter astringent taste, and acid reaction.

Authorities.—Millspaugh's *Medicinal Plants*, Hughes' *Pharmacodynamics*, Gray's *Manual of Botany*, *Amer. Hom. Pharm., U. S. Dispensatory*.

REMARKS ON PROVINGS.

This study of thuja is based on the results obtained by the Austrian Provers' Society as recorded in Metcalf's *Homoeopathic Provings*, together with an accidental proving by Dr. Dudgeon.

The provers, as a rule, employed the tincture prepared according to the Hahnemannian method, or else used dilutions varying in strength from the 1st to the 12th. One of them, Dr. Frölich, recorded the effects of chewing the branches, and also the effects of the fresh juice; another, Dr. Böhm, used the 1st centesimal trituration of the dried twigs; Dr. Mayrhofer proved the tincture and also the oil of thuja, made by distillation of the twigs; and Dr. Dudgeon records the distressing results upon himself of chewing a green cone.

The work of the Austrian Provers' Society is remarkable for the persistence and boldness of the provings.

The experiment in many cases was continued, although very painful and even alarming symptoms were produced, and the drug was taken in enormous doses. The boldest of the provers, Dr. von Zlatarovich, beginning with 6 drops of the tincture, increased the quantity to 1000 drops at a dose, and in one hundred and fifty-five days took 42,260 drops. The quantity taken by Dr. Reisinger and also by Dr. Mayrhofer reached finally 2 ounces at a dose.

It is altogether likely that these enormous doses produced symptoms not to be credited properly to the drug, by reason of local action as well as the presence of alcohol in considerable amount; and study of the reports of the different provers seem to lead to the conclusion that more complete provings would have resulted from the use of the 1st or 2d dilution.

None of the experimenters kept a record of health previous to the proving.

The following symptomatology is made from the records of twenty-six provers, six of whom were women and twenty physicians.

GENERAL SPHERE OF ACTION.

Thuja, contrary to the usual opinion held of it, has quite a wide range of action, affecting chiefly the nervous and muscular systems and the sexual and generative organs; leaving almost untouched (unless given in massive doses) the alimentary canal, except at its outlets, and affecting the circulation only in the peculiar febrile movement.

The influence on the nervous and muscular systems is shown almost entirely by the presence of pains. These are varied in character and location; almost every kind of pain having been felt, and few muscles of the body seem to have escaped these sensations.

Like most resinous products, thuja affects the mucous membrane of the genito-urinary tract, but seems not to act with sufficient force to affect the larger glands except in a secondary manner, though the smaller ones, which are closely connected with the mucous membrane (*i.e.*, the muciparous, prostate, etc.), feel the influence of thuja.

SYMPTOMATOLOGY.

(Provers, 26; men, 20; women, 6.)

GENERALITIES.

Great general weakness¹.

Glandular enlargements².

Pain is felt in small spots⁵.

Character of the pains: stitches³⁶; drawing²¹; tearing¹⁹; drawing-tearing⁴; sticking¹³; burning¹⁰; griping⁸; pressing⁶; lancinating⁷, as if from a thrust²; bruised⁴; cutting⁴; pinching²; biting².

Periodicity of symptoms⁵.

Mind.

Gloomy⁴. Anxious². Alternations of cheerful and melancholy moods².

Inclined to be angry². Ill-humor³.

Mental power impaired⁴.*

Head.

Dulness of the head³; confusion⁴ (dull³). Vertigo⁸.

Headache¹⁰: pressing¹¹; stitching⁷; drawing⁷; aching⁶; lancinating⁵ (as if thrust with a large needle²); tearing³; sticking³; twitching²; pain located in forehead¹² (frontal eminences⁶); temples⁷ (both⁵, right²); mastoid region³; vertex⁷; parietal region³; occiput⁸.

Eyes.

Burning on the margins of the lids⁶; burning and stinging². Quivering of the eyelids².

Feeling as if a foreign body were in the eye². Conjunctiva injected².

Pain in the eyeballs⁶: burning⁴; tearing².

Vision indistinct⁴.†

Ears.

Pains in the concha of the ear².

Transitory pains in the internal ear³.

Abnormal sounds¹⁰: buzzing⁴.

Nose.

Breathing through the nostrils is obstructed³.

Dryness of the mucous membrane³. Burning sensation in the nose².

Sneezing². Coryza, with increased secretion⁴: thin². Bleeding from the nose².

* Expressed as follows: "Great trouble in collecting his thoughts." "Want of disposition to do anything." "Intellectual effort soon fatigues." "Speaks very slowly and monosyllabically."

† Expressed as: "Mistiness of sight." "Obscuration of sight." "Failure of sight." "Could not see or read clearly."

Face.

Pains in the side of the face⁶: transient³.

Pains felt in the lower jaw⁴: running from the angle towards the chin³.

The face is pale².

Mouth.

Toothache³.

Vesicles on the mucous membranes of the mouth².

A feeling of dryness on the hard palate³.

Increased flow of saliva⁷: profuse⁴.

Variations in the sense of taste⁶.*

Throat.

Hawking⁸: frequent⁴; tough mucus².

The throat feels rough⁵, dry³, sore², constricted². Scraping in the throat³.

Deglutition painful³.

Stomach.

Appetite lessened⁶: lost². Canine hunger³.

Increased thirst².

Eructations³: frequent². Nausea⁵: disposed to vomit⁴.

Pains in the stomach⁸; pressure⁴.

Abdomen.

Pains in the hypochondriac region⁴: stitching².

Painful sensation in the abdomen¹³: griping pains about the navel²; pain in the right iliac region²; colicky pains³; parts sensitive to pressure³.

Distension of abdomen⁴.

Rectum and Anus.

Itching about the anus⁷. Pains about the anus¹¹: burning⁴; pressing²; stitching⁴.

Enlargement of rectal vessels³.

Stools.

Diarrhoea⁴: Stools hard³; scanty².

Discharge of mucus or slime from the anus⁴.

* Expressed as follows: "The taste was insipid." "Nauseous taste." "The taste was injured by increased flow of saliva; the food tasted as if not salted enough." "Very unpleasant sweetish salt taste." "Bitter mucous taste."

Urinary Organs.

Sensation of fulness in the bladder².

Pains in the urethra¹⁰: stitching²; burning⁶ (during urination², after³, about neck of bladder³).

Slimy discharge from the urethra². Itching in the urethra².

Urination frequent¹²: with urgent desire⁵.

Urine high-colored³, copious⁹, turbid².

Sexual Organs.

Male.—Pains in the glans⁶: stitches². Itching on the glans².

The glans began to grow moist and secrete mucus².

Burning on the inner surface of the prepuce²; itching⁴.

Pains felt in the testicles⁴: stitches³.

Sexual desire increased⁴; lessened³.

Female.—Menstruation regular but the amount of discharge lessened³.

Respiratory Organs.

Hoarseness².

Sticking or stitches in the lungs³.

Cough¹²: short and dry⁵; with secretion of mucus⁶.

Oppression of the chest¹¹. Dyspnœa⁵: with oppression of the chest⁴.

Chest.

Pressing pains located about the sternum⁴; under it³.

Stitches in the sides of the chest⁹; right⁴; left⁴.

Pressing pain in chest³; right side².

Oppression of the chest¹¹.

Heart and Pulse.

Accelerated pulse². Palpitation².

Neck and Back.

Pains in the nape of the neck⁸: drawing or tensive⁴; tearing².

Stiffness in the nape². Pains in left side of neck³.

Sensation of pain in the lumbar region⁵: painful tension².

Pains in the sacral region³: drawing².

Chilliness in the back².

Pains in the neck or back worse from motion³.

Limbs.

Upper.—Pains in the shoulder⁵ (bruised³); in upper arm⁵

(bruised²); in elbows²; in fore-arm⁴ (burning², drawing-sticking²); in hands⁴ (tearing²); in fingers⁴; in thumb³.

Lower.—Pains in the thigh³; in the knee⁷ (tensive², painful stitches in the left knee³); in lower leg⁴; in ankles⁵ (tearing²); in feet⁸ (tensive², drawing²).

Feeling of weakness in the feet²; lameness³.

Cold feet⁵: icy². .

Drawing pains in great toe².

Skin.

Wart-shaped excrescences².

Round, red spots on skin as large as lentils².

Painful pimples on the skin⁵: on face²; inflamed³.

The skin burns⁴; itches².

Sleep.

Drowsiness⁴: drowsy by day and restless at night³.

Restlessness at night¹¹.

Dreams⁷: voluptuous².

Chill and Fever.

Chill⁴. Chilliness⁸: extending over the whole body⁵; creeping².

Febrile paroxysm⁴: one stage wanting³.*

Sweating⁸: general⁶; sweat on inner surface of thigh².

Periodicity of symptoms⁵: febrile symptoms³.

AGGRAVATIONS.

Pains come on and are felt chiefly while in motion⁵; during rest⁷; during both rest and motion²; pains come on during rest and disappear on motion³.

THERAPEUTIC APPLICATION.

The *headache* of thuja appears to be felt in any part of the head, but it centres in the frontal region, being especially severe in the frontal eminences and extending over the temples, even to the mas-

* "The chill extended over the whole body, merged into a dry and burning heat, and towards morning a sweat broke out over the whole body. The sweat continued until noon and in the evening a chill returned." "Slight shivering which spread over the whole body, followed by a general sudden sweat." "Febrile symptoms came on at night but ceased after midnight, and towards morning perspiration broke out" "In the evening chilliness for several hours passing into burning heat on lying down."

toid region. The usual character of the pain is pressing, or more generally lancinating, as if a sharp needle or similar instrument were thrust quickly into the head. This may be felt in different localities, and the direction of the pain varies. The headache appears to be simply neuralgic and not connected with the condition of the stomach.

In headaches of this character it is generally observed that the eyes are affected also. It is therefore, in accord with this rule that with the thuja patient, burning and stinging on the margins of the eyelids is usual, with quivering of the lids and a feeling as if a foreign body were under them. The *conjunctiva is injected*; burning and tearing pains are felt in the eyeballs, and vision is obscured. This condition of the eye gives hope for aid in the treatment of *keratitis* and other diseases of the external envelopes.

In *haemorrhoids* and *anal fissures* new and efficient remedies are needed, and thuja may yield good results in this locality, inasmuch as there seems to be a tendency for the drug to affect these parts. Itching is commonly felt at the anus, and also burning, stitching, piercing pains. The rectal vessels appear to be enlarged and mucus is discharged from the anus.

Judging from the provings, the diseases most likely to be benefited by the use of thuja are those of the genito-urinary system. The urine is increased in amount and frequently passed, strong urging to do so being felt at times, and it is high-colored and turbid. Itching is felt in the urethra, and pains shoot along it or are felt in certain portions of its course. Burning pains during or after micturition occur, and the bladder feels distended.

This exhibits a fair picture of *urethritis* or even the first stage of *gonorrhœa*, towards which latter disease other symptoms point. A slimy discharge oozes from the outlet of the urethra, and the glans is sensitive and painful.

A condition resembling *balanitis* is suggested by burning and itching on the inner surface of the prepuce and the secretion of mucus under the prepuce covering the glans.

There is sufficient evidence to confirm the use of thuja in *condylomata*, when they occur in combination with gonorrhœa or otherwise. The excrescences are generally rough, hard and exude moisture. The remedy is applied to many forms of *warts*, although in each case the tincture may be required locally.

Few remedies have been observed to affect the *prostate gland*, and yet many persons, especially the aged, suffer from diseases located in

this section. Thuja offers relief when pain and burning are distinctly felt in the urethra, near the neck of the bladder. This may be connected with frequent and urgent desire to urinate, which act, however, causes burning pain.

Notice also the aid which may be gained from thuja in diseases of the respiratory organs. The stitches in the lungs, together with the cough, hoarseness, secretion of mucus, marked oppression of the chest near the sternum, with difficulty of breathing, all point in the direction of help in *pneumonia and kindred diseases*. In the beginning of what is called a general cold, which may result in *rheumatism, pneumonia or bronchitis*, with pains or soreness in all the muscles of the body, and especially through the chest, with fever and oppression of breathing, thuja may do good service.

The muscles throughout the body feel acutely the influence of thuja.

Rheumatism, especially when located in the muscles of the limbs and back (lumbago) should yield to the use of this drug, especially also when pain is a prominent symptom (myalgia). The pains are burning, tearing, and drawing, with occasional sharp stitches and a bruised sensation. The parts may be cold.

Towards *torticollis* the provings plainly point. Drawing, tearing pains in the nape of the neck, with stiffness; the pain increased by motion. Pains are also felt in the side of the neck. Altogether these symptoms give an excellent similitum of stiff neck.

Periodicity is a feature of thuja symptoms, and this appears also in the fever. The *chill* is decided; *fever* is present and *sweating* is profuse. The chill, however, may be followed by a sweat instead of fever; the fever by a sweat without a chill; or chilliness by fever alone. Possibly the missing stage may have been present, but being slightly developed was overlooked. Judging from the provings as recorded, however, thuja would seem to be indicated when a decided chill is followed by a free sweat, the febrile stage being feebly present or entirely wanting.

COMPARISON OF ANALOGUES.

So far as our work has progressed, we find but few drugs whose action is sufficiently similar to that of thuja to make a clear comparison. Among the few that resemble, however, may be mentioned *cannabis indica*, *apis mellifica*, *arsenicum album*, *clematis erecta*, *aloes*, *argentum nitricum*, *æsculus hippocastanum*, and *bryonia alba*.

Cannabis Indica.—Whatever resemblance exists between thuja

and cannabis indica, is in the action of these drugs upon the urinary organs. The urine is copious in both drugs, turbid or high-colored in thuja, while no change in color is noticed as a result of cannabis. Both have urgent desire to micturate, and thuja has burning in the neck of the bladder during and after the flow, which is not noticed in cannabis. The action of cannabis is more pronounced upon the nervous system, the sensorium, while that of thuja is more decidedly upon the mucus membrane; consequently we expect, and find, from thuja, a more powerful effect upon the mucous membrane of the urinary organs in the region of the bladder and urethra, than is obtained from cannabis indica.

Apis Mellifica.—In its effects upon the urinary organs apis mellifica also somewhat resembles thuja in its action. While both drugs have burning in the urethra and frequent micturition, with dysuria, thuja frequently has a large amount of water passed, and apis a small quantity. Apis causes suppression of urine, acts upon the kidneys preventing the excretion of urine; the kidneys present no pathogenetic evidence of the action of thuja; it is the mucus membrane of the bladder which feels its force. Apis and thuja are somewhat alike in their effects upon the eye, the mucous membranes of the eye; both produce an irritation of the conjunctiva. Thuja has a burning and stinging on the margins of the lids, and apis has more of a pricking, itching, with lachrymation which is absent under thuja. Apis also has an oedematous condition of the eyelid, a puffy, bag-like appearance, which thuja does not produce. In both there is indistinct vision. Another differential point is the tendency of apis to produce erysipelas, which is not an effect of thuja. Both have pain in the eyeballs, but here the resemblance ceases.

Arsenicum Album.—The effect of arsenic upon the urinary organs also bears some resemblance to that of thuja. Both have difficult urination, in both the urine is copious, both have burning and urgent desire with high-colored urine, but arsenic produces an influence upon the kidneys which thuja does not. As a result of arsenicum, albumen appears in the urine, also blood, but, while the urine of thuja is high-colored or turbid the pathogenesis shows neither albumen or blood. Both these drugs resemble somewhat in their action upon the respiratory organs; both have hoarseness, though this is more pronounced under arsenicum; both have short, dry cough, and both have dyspnoea. The dyspnoea of arsenicum is more decided than that of thuja, and also there is soreness of the lungs, which is absent from thuja; besides, under arsenicum the general weakness

is greater, with a tendency to œdema which is not noticed as an effect of thuja. This, together with the intense, insatiable thirst, restlessness and emaciation of arsenicum will differentiate it from thuja. In other words, the whole condition produced by arsenicum is more serious, the drug takes a deeper hold upon the organism, and its effects are more lasting.

Argentum Nitricum.—*Argentum nitricum* is another drug that may be compared with thuja. Both have pains in the urethra, with frequent micturition, urgent desire, burning during and after micturition, and increased quantity of urine. Under thuja the urine is either turbid or high-colored, under argentinum it is pale. The pathogenesis of argentinum nitricum shows no discharge from the urethra, while that of thuja exhibits a slimy discharge. Under thuja there is stitching, burning, itching in the urethra, while argentinum nitricum produces a hot, sore feeling, and the urethra is swollen. Again, both drugs resemble in their symptoms of the respiratory organs; both have short, dry cough with secretion of mucus, and while argentinum has much mucus in the trachea and pharynx it lacks the oppressed breathing of thuja. The differential points here are, the larger amount of secreted mucus of argentinum, and the dyspnœa of thuja.

Aloes.—These two drugs resemble in their effect upon the rectum. Thuja produces an enlargement of the rectal vessels, aloes produces a feeling of fulness in the rectum, an irritation of the rectal membrane as from hæmorrhoids; evidently a similar condition to that produced by thuja. Both produce pains about the anus, and burning. The effect of thuja is more limited to the hæmorrhoidal circulation than that of aloes. Aloes produces a diarrhœic and dysenteric tendency far more strongly than does thuja; from its effects there is more general congestion of the whole pelvic viscera than is produced by thuja. In women even the uterus is affected.

Æsculus Hippocastanum.—This is a drug which acts similarly to thuja upon the rectal vessels, both producing an enlargement of these veins. Like aloes, æsculus has a sensation of fulness in this region, a sensation as though the rectum would protrude. With thuja, æsculus has an itching about the anus, but the pains and burning of thuja are absent. In a general way, a diagnostic point between these drugs is, that thuja seems to act more upon the hæmorrhoidal circulation itself and less upon the mucous membrane of this part, while æsculus acts more powerfully upon the mucous membranes.

Clematis Erecta.—*Clematis erecta* somewhat resembles thuja in the

sexual sphere. Both have increased desire. Erections are especially noted under clematis, but not under thuja. Both have pains in the testes, but pains in the cord are more marked under clematis than under thuja. Thuja causes an itching of the prepuce; clematis causes an itching of the general genitals.

Bryonia alba.—There is another drug which has a striking resemblance to thuja in some particulars, and it is a drug of which we do not often think in relation to the conditions in which thuja is indicated. This drug is bryonia alba. As a result of bryonia we have muscular symptoms similar to those produced by thuja. Thuja causes pains throughout the whole body; all the muscles seem to be affected, from the shoulder to the hand, and from the hip to the toes. It even has the sticking pains in the chest, and the drawing, tearing pains throughout the other muscles of the body. The head is also somewhat similarly affected; there is marked headache, dulness, confusion, and vertigo. The pain is chiefly pressing in character, and is located in the frontal region. All this resembles bryonia, but the bursting sensation of the head common to bryonia is not so prominent a feature of thuja. Even the heart is accelerated in its action in both drugs; both produce a febrile tendency, and altogether there is a strong resemblance between the action of these two drugs, particularly upon the muscular system and the mucous membrane. The mucous discharge of bryonia is thicker than that of thuja. Both produce hoarseness and sticking pains in the chest; both produce a short, dry cough; and both have oppression of the chest and dyspnoea.

There are many other drugs which resemble thuja more or less closely at various points, but the foregoing are probably some of the best examples of drugs whose analogical effects can be clearly differentiated without calling upon clinical testimony to corroborate pathogenetic evidence.

REPORT OF THE COMMITTEE ON DRUG PROVINGS.

BY A. W. WOODWARD, M.D., CHICAGO, ILL.

(Read before the American Institute of Homœopathy, Washington, D. C., June 15, 1892.)

BEFORE presenting our report, which includes eleven experiments with ipecacuanha, three with rhus toxicodendron, and ten with pulsatilla, a word of explanation is necessary. These provings were

not undertaken to obtain the pathogenesis of these drugs, but for a distinctly different purpose, namely, to ascertain :

1st. The location of their primary action.

2d. The order of development of effects, as shown by the sequence of physiological disturbances produced in each case.

3d. Whether the same drug produces a similar, or different sequence upon persons of different temperament.

4th. To find the group of physiological derangements which are peculiar to each drug when its full effects are produced.

To facilitate this study, the symptoms appear in the order of their occurrence, and those indicating the first disturbance of a different function are italicised.

IPECACUANHA.

New Experiments.—Dr. G. P. Howard, of sanguine temperament, in good health, pulse 72, took 20 drops No. 10, drug unknown (tinct. ipecac.), in water. He soon had a sharp pain beneath the ensiform cartilage, with *sinking sensation in stomach*, followed by a *pain through the chest* from side to side, relieved by deep breathing and aggravated by expiration.

Slight headache in temporal region.

Called to urinate (unusual hour), nausea and increasing headache, felt chilly, *uneasy and restless*, he was afraid he had taken too much medicine. These symptoms were attended by recurring pains in epigastric regions and chest, with nausea, eructations and headache ; urination was more frequent during that day.

Second Experiment.—One week later he took 10 drops of same drug. Soon after *dryness of the pharynx* and slight pains in stomach followed by *sneezing*.

Perspiration on the hands and face without cause.

An urgent call to urinate (unusual hour), stitching pains in right supra-orbital region. Pricking pains in the rectum and a feeling in the nose as if he had inhaled sulphur fumes. Later he had stitching pains near the right nipple with occasional cough. He urinated more often than usual during the evening. The next morning his tongue was coated and he had no appetite.

Dr. L. C. Fritts, lymphatic temperament, took 10 drops No. 28, unknown drug (tinct. ipecac.), in water. He had *increased saliva* with slight nausea, much mucus in throat which caused gagging. Later nausea increased with *sneezing and watery nostrils*. One hour after taking, the thought of eating caused nausea ; *chilliness when walking in the open air*.

Second Experiment.—After an interval, being in good health, he took 20 drops of the same drug. *Increased salivation* followed by *increased mucus in nares*, bitter taste and persistent nausea, afterward a copious liquid stool.

Third Experiment.—After another interval he took 25 drops of the same. *Increased saliva with paroxysmal sneezing*, and a *prostrating* nausea with retching; after two hours, *headache* and chilliness; in the evening *the urine was scalding*.

Fourth Experiment.—Two weeks later he took 10 drops of same medicine. *Offensive taste* and increased saliva. *Hiccough* and nausea with *pressive pains in temples*. Frequent eructations, nausea and chilliness, nausea *increased by stooping*, which caused retching and salivation. Nausea returned at intervals and seemed to alternate with symptoms of severe cold with much sneezing and stuffed feeling in chest. During the night urgent call to stool with much tenesmus; toward morning *unusual sexual excitement*. Second day, *increased urination*, with an unusual sense of fatigue toward evening, *could not apply his mind to study*, numbness and aching in left arm from shoulder to fingers, with oppression of chest. For three days following he had no appetite and could not eat.

Dr. W. H. Mansifee, mulatto, of nervous temperament, after taking 10 drops No. 30, unknown drug (tinct. ipecac.), *had nausea* followed by *stoppage of nostrils as from a cold*. Later pain in stomach and cough of irritating character with dryness in throat. *A tired feeling which he could not explain*. The calls to urinate were of greater frequency and the quantity increased.

Wm. Martin, of bilious temperament, pulse 65, health sound, took five drops No. 26, unknown drug (tinct. ipecac), in water. *Dryness of mouth and throat* with slight nausea. *Slowing of pulse* to 54 per minute. *Headache in frontal region* with occasional griping in bowels. Pulse normal, pain in abdomen increased as if dysentery were coming on, attended by chilliness and *aching in the wrists as if sprained*. *Called to urinate at an unusual hour*. This was repeated more often than usual during the afternoon, and brought relief from other symptoms.

Dr. W. M. Stearns, nervous temperament, pulse 80, in good health, took 30 drops No 17, unknown drug (tinct. ipecac.). *Increasing nausea*, attended by rumbling and pinching in the bowels. *Pulse 96, full and hard*, with a *flushed face* and a hot, moist skin. Copious stool, preceded by griping, followed by *wandering pains in back and limbs*. During the P.M. was annoyed by frequent calls

to urinate. Nausea returned at intervals and tongue coated, pulse normal, symptoms of a fresh cold in nose and throat.

Dr. T. C. Buskirk, bilious temperament, pulse 65, took 5 drops No. 10, unknown drug (tinct. ipecac.) in water. *Soon severe nausea*, which prevented eating, *fulness in frontal region* as if a cold was coming on, with *dull headache*. Occasional eructations, with fulness and distension of abdomen, accompanied by much itching of the face (unusual); during the P.M. stoppage of the nose and photophobia. Frequent yawning and *stretching*, with renewed nausea and chilliness as from ague. This was followed by aching in back and shoulders that prevented study. At 4 P.M., *profuse diuresis* which relieved the pains. Later he found himself *very impatient and indisposed for society*.

Second Experiment.—At the expiration of one week, health being good, he took 15 drops of the same vial as before. *Extreme nausea and retching* followed by colic, flatulency and eructations. *Severe hicough*. *Frontal headache* which gradually increased, *exercise caused unbearable pains in head*, his stomach and abdomen continued to distress him until he had two copious stools. Before this occurred there was considerable dyspnoea, especially when exercising. No renal symptoms were noticed.

Upon reviewing these provings it will be observed that while the symptoms at each stage were of different character and location, most of them belonged to the same physiological group of organs, for example :

The first symptom given by these provers severally was sinking at stomach, dry mouth, increased saliva, increased saliva, increased saliva, offensive taste, nausea, dry mouth, nausea, nausea, extreme nausea. These were disorders of the alimentary canal or organs of digestion.

The second symptom was pain in chest, sneezing, sneezing, watery nostrils, sneezing, hicough, stoppage of nostrils, slower pulse, increased pulse, catarrh in head, hicough. These were symptoms of the respiratory and circulatory organs.

The third symptom was headache, perspiration, chilliness, prostration (?) headache, headache, headache, flushed face, dull headache, headache. These were phenomena of the skin and sensorium.

The fourth symptom was call to urinate (?), call to urinate (?), urine hot (?), aggravation on motion, a tired feeling, aching in wrists, wandering pains in limbs, stretching, aggravation on exercise. Here there was probably some transposition of symptoms, the majority, however, being of spinal origin.

The fifth symptom was restlessness (?), worse on walking (?), hot urine, worse on stooping (?), call to urinate, call to urinate, frequent urine, profuse urine. At this stage most of the symptoms are of the urinary organs.

Thus there is practically a uniform sequence of physiological effects produced by this drug in these cases, namely, *digestive, respiratory or circulatory, cutaneous, spinal and renal* symptoms seriatim.

This sequence is confirmed in large measure by cases of poisoning by this drug, as will be found upon reference to the *Cyclopædia of Drug Pathogenesis*. It will further appear in those cases that they present a combination of symptoms arising from these several functions, which sequence or combination must, by the law of similars, constitute the true indications for the use of this drug as a therapeutic agent.

Therapeutics.

If this sequence is adopted as a guide in practice, special symptoms not having been produced, cannot be made use of, consequently the choice of this remedy must be determined by other indications. These are to be found in the comparative severity or prominence of the disturbances shown by these organs respectively. Referring to the provings, the symptoms of the alimentary canal were more serious than those of the lungs or skin, and those of the skin than those of the spinal centres or kidneys, hence the indications for the use of ipecac exist not only in this particular group of derangements, but in the fact that, next to the local lesion, the symptoms of the digestive organs are most severe, those of the respiratory or circulatory are of second importance. The cutaneous are third, the spinal are fourth and renal are fifth in point of gravity. The following cases already published illustrate the truth of this proposition:

Gastric Catarrh.—An old lady was taken suddenly with distressing nausea, followed by vomiting large quantities of mucus. The paroxysm lasted two hours. During the vomiting she suffered greatly from oppression of the chest and palpitation of the heart. She became pale and cold. These paroxysms had continued at intervals for five days, increasing in violence. When called I gave her ipecac. 200, one dose, after which she slept and had no further trouble.—Hempel's *Materia Medica*.

Cholera Morbus.—A gentleman after eating heartily became nauseated; finally copious vomiting and frequent stools occurred, attended by an excited pulse, dyspnoea and a coldness of the surface of the

body. Ipecac. 30 was given, arresting the disorder promptly.—Dr. Guyard, *Beauvais Clinique Medicale*, 551.

Tracheitis.—A child who had been subject in early life to frequent attacks of diarrhoea was taken with catarrhal symptoms while cutting her teeth; soon there developed a very dry cough with difficult inspiration; the expiration was easy but noisy, occasionally there was a complete arrest of breathing and threatened suffocation. Attending this condition there was excessive tympanites and rolling of flatus, cold sweat and pallor, some restlessness and frequent scant urine. The pulse was rapid and weak. Ipecac. was given with relief in half an hour. A cure rapidly ensued.—Dr. Trinks, *Beauvais*, 4104.

Bronchitis During Pregnancy.—Mrs. L. was in good health until pregnancy occurred. Since that time she has suffered from loss of appetite, nausea and vomiting every morning. These symptoms continued until four weeks since, when a severe cold developed, attended by dyspnoea and copious expectoration. The paroxysms of cough ending in retching and vomiting. Of late she has emaciated rapidly. Her urine has become scant and loaded with lithiates. Wine of ipecac. was given with a rapid and complete cure. Dr. C. D. Phillips, *Braithwaite*, vol. 60, p. 243.

Epileptiform Convulsions.—Child aged four years was having frequent spasms, with loss of consciousness. There was much dark mucus in the mouth, and occasional efforts to vomit. Respiration irregular, severe cough and tracheal râle constant. The inspiration was short followed by sighing expiration, as if each would be the last. The skin was hot and flushed. There was incontinence of urine. Ipecac. was given with immediate relief.—Dr. Rummel.

Post-Partum Hæmorrhage.—I arrived too late, the child was born. I inquired of the patient, "how do you feel?" "I am so sick at my stomach; it is getting dark." Her eyes were glassy and fixed, her face blanched. She was pulseless, her abdomen was distended and a bright crimson torrent was issuing from the vulva. Ipecac. produced an immediate arrest of the hæmorrhage, with complete contraction of the uterus in a few minutes.—Dr. C. M. Conant, *Am. Homœopathist*, Dec., 1878.

RHUS TOXICODENDRON.

New Experiments.—Dr. R. W. Conant, nervous temperament, pulse 80, took 10 drops No. 16, unknown drug (rhus tox., 1x) in water. *Itching of the scalp and face*, later extending to other parts.

A feeling in the left elbow as if sprained, worse from movement. Itching continues. Aching and lameness in the sacro-lumbar region. Sharp pains in the right shoulder and knee, with burning and smarting of eyes. Headache. *Sneezing repeatedly*, with chilliness in the open air. Pulse 90. He suffered from lameness in the right ankle, and stabbing pains in hip-joint when at rest. *His usual stool was tardy and scant*. Neuralgic pains in right crural nerve. Frequent eructations. Soreness and stiffness in right arm and wrist. Headache and *depression of spirits*. Urine normal. 9 p.m., pulse 96 with heat and chilliness. He was very restless and uneasy because of the pains in his limbs. He also complained of pulsations in the chest and abdomen, and feared he would become ill.

Dr. T. E. Roberts, sanguine temperament, pulse 72, took 10 drops No. 4, unknown drug (rhus tox., 1x) in water. *Burning heat of forehead* followed by perspiration without cause. *Pains in right knee* which were worse on moving. *ringing in ears*, pulse 80. Pains in knee return, he is chilly without cause, wanted to be near the stove. Backache, relieved by exercise. *His throat felt dry and parched*, he felt flashes of heat and pain from shoulder to wrist of right arm. *He was dull and sleepy*, and the abdominal walls felt as if bruised.

Second day, sleep was good, waked with a headache, relieved by rising. *Sharp pains in left spermatic cord* with itching of scrotum. Neuralgia pains in right ear and temple. Much flatulency with eructations and griping in bowels. Pulse 60.

Third day, the pulse before rising 50, wandering pains in different parts, relieved by rising. The tongue coated in centre with red papillæ on edges. Slight nausea at the sight of food. After eating, pains in the abdomen increased until he had a difficult stool, which brought relief.

Dr. A. W. W., lymphatic temperament, pulse 65, took 10 drops rhus radicans, 1x, in water. *Chilliness*, and soon after cold hands and feet. The chilliness increased when at rest and was relieved by exercise. *Restlessness without pain*, nervous, pulse 84, chilliness returns with aching in feet. Dull headache *with sleepiness*, he could not read with interest. *Griping in abdomen* as if diarrhœa would occur. Neuralgic pains and itching in various parts. The griping returns at intervals. Stiff neck for a short time with soreness to touch. The nose was obstructed as if from a cold. Later an urgent call to stool. Sensitiveness to cold air, pain in thighs and occasional sneezing. *Urination later than usual*. Irritating cough in evening

as from relaxed palate. Dull backache, pulse 96, with occasional chilliness (temperature not taken). The stiffness and soreness of muscles in neck returned, preventing sleep until a late hour.

Second day, pulse on waking 98. He felt chilly and languid. After rising a copious watery stool with urging. Study was difficult during the day. His feet were lame when walking; in the afternoon neuralgic headache, with soreness of scalp. Distension of the bowels, followed by a copious stool with relief of all symptoms.

The following table indicates the sequence of symptoms from these provings :

	First Symptom.	Second Symptom.	Third Symptom.	Fourth Symptom.	Fifth Symptom.
Dr. Conant...	Itching in various parts.	Strained feeling in elbow.	Burning of eyes. Sneezing.	Scant stool.	Depression of spirits.
Dr. Roberts.	Burning heat of face; perspiration.	Pain in knee; worse on motion.	Ringling in ears. Pulse 80.	Throat dry and parched.	Dull and sleepy.
Dr. A. W. W.	Chilliness and coldness.	Restlessness.	Pulse 84.	Headache and sleepy.	Gripping in abdomen.

To these should be added 15 cases of poisoning already published, in which the primary cutaneous symptoms are followed by motor disorders. Of 12 cases which show further action, 8 indicate respiratory or circulatory phenomena third in order of development. Most of the records end here. Five, however, present mental symptoms next, only 3 exhibiting gastro-enteric disorders at any time.

This indicates that the physiological sequence of derangements produced by this drug is as follows : *Cutaneous, Spinal, Respiratory or Circulatory, Mental and Gastric* disorders seriatim, and by our therapeutic law, the successful use of this drug as a remedy will be limited to cases showing this order of development and this group of symptoms.

Therapeutics.

Sciatica.—O. W., aged 35, has dull aching pains in right hip and leg, aggravated at night, and by cold or dampness, relieved by heat or exercise; he is excessively uneasy, cannot rest in any position. Muscular twitching occurs in all parts of the body. Cannot sleep at night. Pulse and temperature not taken. After six months of suf-

fering, rhus 30x, relieved and cured promptly.—Dr. D. A. Gordon, *A. J. H. M. M.*, vol. 9, p. 29.

Acute Rheumatism.—A man was taken suddenly with a chill followed by drawing pains in the limbs and copious sweats. On the fifth day I found him suffering with tensive drawing pains in the legs, involving joints and muscles. There was constant restlessness which relieved. He complained of a feeling of numbness all over. The affected joints were extremely painful to touch, red and shining. Heat increased the pain, as did also exposure to cold air. With these symptoms the pulse was full and rapid and respiration short. He was sleepless both day and night. Occasional craving for food, but usually indifferent. Thirst at night. Rhus tox. 24x, brought convalescence in four days.—Dr. Gross, *Beauvais*, 3340.

Angina Pectoris.—Mrs. L., aged 58. Five years ago she became chilled from handling ice. The next day she could not move, she was so stiff from rheumatism. In the course of time this subsided, and facial erysipelas was developed. Three days later this disappeared and she was taken with dreadful pains in the region of the heart; this has continued more or less ever since. When a paroxysm seized her she must jump up and walk rapidly as the only means of relief. She is worse in stormy weather and is always a poor sleeper. Rhus 3x did no good. The 30x, however, arrested the paroxysms permanently in ten days.—Dr. O. Blatchley, *Medical Advance*, March, 1884.

Spinal Meningitis.—Miss F., after exposure to a storm, was taken with violent pains in her head and spine. Decided opisthotonos existed, and the slightest touch or movement caused excruciating pains. Pulse 50, complete insomnia, bowels almost paralyzed. Various remedies were tried without benefit. Finally rhus 6x gave speedy relief and a gradual recovery followed.—Dr. Dittrich, *Hoyne's Therapeutics*.

PULSATILLA.

New Experiments.—Dr. T. E. Roberts; sanguine temperament, in good health, pulse 72, took 5 drops No. 46, unknown drug (pulsatilla tinct.), in water.

Increased saliva followed by a griping in left hypochondria.

Pricking, burning pains in different parts of shifting nature.

Sneezing and watery nostrils soon followed by *twitching in left leg*. Eructations at intervals, tasting of food. While walking, he had unusual warmth with itching in various parts, throbbing in blood-

vessels. Pulse not taken. After another dose increased saliva, pains in stomach and abdomen and violent itching.

Second day, the stool was insufficient. Dull headache on rising *and drawing in left spermatic cord* when walking. Painful fulness of right eye. No appetite for breakfast. Pains of neuralgic character about the heart. *Felt discouraged and took no more medicine.* The skin symptoms persisted at intervals for nearly a week. Appetite was bad and bowels irregular. Pulse showed no variation at any time.

Dr. G. P. Howard, sanguine temperament, in good health, pulse 72, took 5 drops No. 24, unknown drug (pulsatilla tinct.), in water.

Distension of stomach, followed by eructations.

Neuralgic pains in left foot, causing him to rub it for relief.

Afterward shooting pains in right tibia. Eructations continued, with occasional shooting pains in left wrist and knee.

Eyes seemed irritated and inflamed, stuffy feeling in nose with pressive headache as from a cold. *No urine was discharged for 24 hours* after taking medicine (unusual).

Second Experiment.—After an interval of two weeks he took 3 drops of the same medicine in water.

Eructations with rumbling in bowels, followed by tingling and itching in various parts.

Repeated sneezing and watery fluid from nostrils.

Dull pain in right ear with ringing. Irritation in nose continues. *Neuralgic pain in left testicle.* It felt heavy and tender to touch. Eructations continue at intervals. No appetite for lunch. Pulse 84, chilly out of doors. *Could not apply his mind to study.*

Second day his sleep was dreamful, tongue coated; on waking no appetite. Backache when moving, with a tired sensation. Eyes slightly agglutinated.

Dr. A. W. W., lymphatic temperament, pulse 65, took 10 drops No. 7, unknown drug (pulsatilla 1x), in water.

Tasteless eructations, with fulness of stomach.

Itching of scalp and face, with increased saliva.

Heaviness and fulness under the sternum, with oppressed respiration. Repeated eructations with sweat in axilla. Much flatus passed, with colic. Eyes watery.

Dull aching in back, with drawing in hands and feet.

Aching and heaviness in testes. Pulse 90. Slight chilliness, worse out of doors. Face hot, hands and feet cold. Flatulency and eructations quite annoying. Occasional nausea with headache.

Testes sore to touch. Irritating cough when lying down.

Felt very weary and *overpowered with sleep*, was awakened by coughing, soon after urging to urinate (unusual hour). Gripping in bowels followed by loose stool and *scant urine*. Soon after sharp pains about the heart, with sinking at stomach and despondency of mind. No appetite for evening meal. Tongue whitish and taste offensive, eating renewed nausea. 9 P. M. Toothache shifting from one to the other. Pulse 98. Chilliness when moving. Rheumatic pains prevented good sleep.

Second day, catarrhal secretion from nose. This continued for two days, with loss of appetite and tendency to chilliness.

Dr. H. W. Bassett, nervous bilious temperament. Pulse 80, took 5 drops No. 29, unknown drug (*pulsatilla tinct.*), in water. *Emptiness of stomach*, followed by sense of *heat in face*. *ringing in ears* when stooping. Pulse 92. Neuralgic pains over left eye, extending to left ear. After another dose of 15 drops, there was nausea with coldness of legs and feet; no other symptoms noted.

Dr. Thomas Lawson, sanguine temperament, pulse 75, took 5 drops No. 29, unknown drug (*pulsatilla 1x*), in water. *After one hour, face hot, dry and flushed*, slight headache. Pulse 86. His eyes became inflamed and sensitive to light. *Felt very tired without cause*, much mucus in throat, with disposition to cough. *Stomach felt empty*.

At noon distension of stomach and abdomen after a moderate meal. Copious vomiting occurred relieving all symptoms.

Second Experiment.—After an interval of one week he took 5 drops as before.

Two hours after, lips and skin dry and hot. Eyes watery. Photophobia. Pulse 96, weak. He *felt very tired*, had frequent yawning, and *could take no interest in anything*.

Headache in the warm room, very hungry before supper. Ate moderately, but *vomited soon after*.

Second day, a red rash resembling measles, was observable in various parts of the body, attended by much itching, loss of appetite and coated tongue.

Dr. Wm. E. George, nervous temperament, pulse 72. After taking 10 drops No. 3, unknown drug (*pulsatilla 1x*), in water. *Dryness of mouth*.

A feeling of coldness in left temporal region.

Pulsations in head with aching in eyeball and eructations.

Pulse 66.

After another dose, headache and throbbing in vertex. Pulse 60,

neuralgic toothache, mouth felt as if after using alum, ringing in ears, eructations, neuralgic pain in right foot.

Second day, chilliness on rising, call to stool at an unusual hour, loose and copious. *Urine copious.*

Second Experiment.—After an interval, health being restored, he took 10 drops of same medicine.

Dryness of mouth and throat.

Throbbing and fulness in head, with neuralgic pains in ears.

Sinking at the stomach. Burning of eyelids. *Pulse 84.*

Another dose caused chilliness along the back and *weakness of the legs*, followed by nausea. *The urine became pale and copious.* During the night rumbling in the bowels and pressure in the rectum, followed at 11 P.M. by a frothy stool with relief.

Dr. A. Rasmussen, Atrabilious temperament, pulse 60, took ten drops No. 4, unknown, drug (*pulsatilla tinct.*), in water. *Eructation followed by oppression of stomach.* No further symptoms until the next day, when the dose was repeated. This caused a return of the oppression in epigastrium, attended by *flushing and fulness of blood-vessels in face* with heavy feeling in rectum. After several days a third dose caused eructations and headache on vertex.

The following synopsis (page 553) of these experiments shows the sequence of the symptoms in each case:

It should be mentioned, that these, together with fifteen other provings already published, show that probably seventeen out of twenty-five cases, gave uniformly the same sequence as follows:

Digestive, Cutaneous and Respiratory or Circulatory phenomena seriatim. Beyond this eight cases show *Spinal* symptoms fourth, and five give *Genito-urinary* fifth in order of development.

This sequence being so uniform, it is reasonable to conclude, that it indicates the individuality of this drug, and will prove a correct guide to its use as a therapeutic agent. This is illustrated by the following cases:

Therapeutics.

Dyspepsia.—A woman had suffered for several years with daily attacks of cardialgia, as from ulceration. With pinching cutting pains in the stomach and bowels and constipation. Attending, there was pallor, frequent chilliness, with yawning and stretching of limbs, burning heat of palms of the hands, tenesmus of the bladder, and scant and painful menstruation. She made a permanent recovery after a few doses of *pulsatilla*.—Hempel's *Materia Medica*.

	First Symptom.	Second Symptom.	Third Symptom.	Fourth Symptom.	Fifth Symptom.
Roberts.....	Increased saliva.	Prickling and burning skin.	Sneezing.	Jactitation.	Drawing in spermatic cord.
Howard.....	Eructations and rumbling in bowels.	Tingling and itching skin.	Sneezing and watery nose.	Neuralgic pains in testes.	Tired sensations.
Howard.....	Eructations and rumbling in bowels.	Neuralgic pains in left foot.	Nose stop'd.	.....	.....
A. W. W....	Tasteless eructations.	Itching of skin.	Heaviness under sternum.	Backache.	Aching in testes.
Barrett.....	Emptiness of stomach.	Heat of face.	Ringing in ears.	Pulse 92.	.....
Lawson.....	[Probably omitted.]	Face hot and flushed.	Pulse 86.	Very tired without cause.	Vomiting. (?)
Lawson.....	[Probably omitted.]	Skin dry and hot.	Eyes watery.	Pulse 96.	Vomiting. (?)
George.....	Dry mouth.	Cold skin.	Pulsations in head.	Pulse slower.	Urine copious.
George.....	Dry mouth.	Neuralgic pains.	Burning eyelids.	Weakness of legs.	Urine copious.
Rasmussen.	Eructations.	Flushed face.	Fulness of bloodvessels.	.....	.....

Chlorosis.—A girl, aged 15, who had never menstruated, was of extremely anæmic appearance, complained of nausea, anorexia, colic pains and constipation. She had fever at night with cramps in limbs and headache. Pulsatilla 30x produced a rapid change for the better; in two weeks menstruation was established and her color soon became natural.—*Beauvais Clinique Medicale*, 488.

Hæmoptysis.—Miss —, aged 37, has been an invalid for years, has frequent painless cough, soreness and heaviness of left chest. With these symptoms she is dyspeptic; milk distresses her. She has cold feet and hands and flushed face, also increasing debility, and premature and excessive menstruation. Pulsatilla arrested the hæmoptysis at once, and in four months she reported herself cured.—Dr. G. O. Spence.

Epileptiform Convulsions.—A girl, aged 18, with no heredity, has had amenorrhœa for six months, convulsive seizures about once in two weeks. Premonitory aura, masticating motions of jaws, cadav-

eric pallor and dyspnoea. Pulsatilla was given; the following month menses returned, and convulsions ceased, no relapse has occurred after four years.—Dr. Bojanus.

Dysmenorrhœa.—Madam E——, has always been subject to premature and painful menstruation. She is habitually constipated, and during the period is troubled with nausea and severe pain in the bowels. She has frequent attacks of vertigo, also dyspnoea. Her breathing is short and irregular. She has sleeplessness and great despondency. Pulsatilla cured permanently in one month.—Dr. Ruckert, *Beauvais*, 1000.

Amenorrhœa.—A lady after suppression of menses, was taken with a violent cough, dyspnoea and palpitation of the heart. These symptoms were attended by frequent attacks of vomiting, burning heat of face, chilliness, pulsating headache, trembling of limbs, rapid emaciation and loss of strength, with depression of spirits. Pulsatilla gave immediate relief. A rapid recovery followed.—Dr. Weissenus, *Beauvais*, 77.

Abortion.—A pregnant woman, for several days had complained of anorexia and nausea. She was taken with chilliness attended by pallor and flushing of countenance. Pulse weak, faintness, eyes sunken, tongue coated white, loss of appetite, pains in chest. These disorders were followed by labor-like pains in hypogastric region, and slight discharge of blood from vagina. These symptoms which had increased for several hours, were quickly arrested by pulsatilla.—Dr. Teitze, *Beauvais*.

Insanity of Pregnancy.—A woman eight months pregnant, usually of gay and happy disposition, became cold, morose and silent. Finally she was sleepless and had frightful delusions at night. These symptoms were attended by thirst, flushed face, pain in back and limbs with prostration. Belladonna failing, pulsatilla was given with rapid relief of all symptoms. Her labor was natural.—Dr. Bethman, *Beauvais*, 9.

While the drug sequence thus indicates the group of concomitants, for which the drug will prove curative in acute affections, it is of even greater importance as a guide in the treatment of chronic disorders.

Experience in our college clinic has proved that the sequence of the indicated remedy corresponds exactly with the sequence of diseases which have occurred in the clinical history of these patients prior to the development of the chronic disease. For example:

CASE 47,202.—O. G., aged 51. Hypochondriasis and headache of five years' duration, suicidal tendency. Pains worse at night. No other symptoms obtainable. *Clinical history*: Infantile eczema, followed by paralysis for two years. This disappeared after scarlet fever. When six years of age inflammatory rheumatism, of which he has reminders whenever exposed to the weather. No cardiac lesions discoverable. Ten years ago he had pneumonia, and since the headaches became so severe he has had a weak stomach. Guided by this clinical history of cutaneous, spinal, respiratory, cerebral and gastric disorders, rhus tox. 30x cent. was given. Two weeks afterward he was a changed man. The cure was permanent.

CASE 44,127.—C. E., aged 45. Gonitis and partial ankylosis of four years' duration, caused by a sprain. No other symptoms apparent. *Clinical history*: Eczema in childhood, which returns occasionally to this day. Rheumatic fever during his ninth year, induced by exposure in a snow-storm. Since manhood he takes cold easily, and has an obstinate cough with some rheumatic pains. When 32 years of age bronchitis developed, which confined him to the house most of the winter. Of late he is troubled a good deal with insomnia. Other functions are normal. Aside from the local lesion the clinical history in this, as in the former case, pointed to rhus tox. This remedy was given in the 30x with little effect except reduction of the swelling. The 200x, however, cured the case in two months.

CASE 46,898.—Mrs. E., aged 30. Bronchitis of two years duration. Cough attended by copious expectoration. There is considerable emaciation and night-sweats in first sleep. She is losing strength and has always had a weak stomach. Menstruation is scant and painful. *Clinical history*: Cholera infantum severely. Measles followed by whooping cough, during her fifth year. Nasal catarrh since that time. Rheumatism at 16 years of age. Menstruation established at 18. It has always been scant and painful. The clinical history in this case serves to emphasize the attending symptoms. Guided by the sequence of gastric, cutaneous, respiratory, spinal and sexual disorders. Pulsatilla 30x was given. Improvement began with relief of the dysmenorrhœa. The cough ceased in six weeks and she was well.

CASE 46,772.—Miss B., aged 30 years. Chronic metritis. Has done no work for four years. She has had pains and soreness in her lower abdomen since her sixteenth year. Menses every twenty-one days, continuing ten days. Complains also of weak stomach and constipation. She catches cold easily which results in bronchial cough. She appears quite anæmic and is easily tired. *Clinical history*: Gastric fever at 6 years of age. Measles at 10. Whooping cough at 16. Menstruation soon after. She has never had rheumatism, but has more or less rheumatic pains every winter. Rapid improvement followed the use of pulsatilla 30x in this case, first manifested by relief of the uterine symptoms.

Other cases in our clinic show that the constitutional history of the patient is a reliable guide to the selection of the remedy in all chronic diseases, whatever may be their nature, locality or duration.

In severe forms of acute disease, as seen in private practice, more than one physician has found that, in pneumonia for example, it is better to neglect the pathognomonic or local symptoms as indications for treatment, and adapt the remedy to the concomitant disorders, which, as a rule, coincide with the clinical history of the patient. The only exception which has been found to the general application of this rule is in epidemic or infectious forms of disease or in cases already modified by drug action.

The conclusion to which these observations lead is that all grave pathological conditions, as a rule, are modified if not produced by other disorders which have preceded. Consequently if the sequence of causes is met by a remedy operating in the same direction the result in most instances must be satisfactory. Such being the indications for treatment, medical men should learn the individuality of each drug, as shown by the sequence of derangements it is capable of producing; this done, a scientific therapeutics will be attainable.

ANTISEPSIS, GENERALLY SPEAKING.*

BY T. L. MACDONALD, M.D., WASHINGTON, D. C.

THE time allowed for bureau reports, at the last meeting of the American Institute, was far too brief, and on this account Dr. Peck, with his usual good nature, omitted the reading of his own paper, and gave to others the time that rightfully belonged to him. At the opening of this reply let it be understood that it is to be a discussion of his statements, opinions, and conclusions, not of his personality. Of that there can be no discussion, for true discussion implies difference of opinion, and we are all alike agreed as to his well deserved popularity, and respect him for his intelligence, zeal, and good nature. Then, too, his article is characterized by honesty of purpose and that dignity which should always attend the consideration of scientific questions. Dignity is of itself a forceful argument, and although it does not prove the correctness of his opinions, it does prove the sincerity of his convictions. His paper was entitled,

* A reply to Dr. George B. Peck, of Providence, whose article was published in the *HAHNEMANNIAN MONTHLY* for July, 1892.

"The Practical Relations of Homœopathists to the Germ Theory;" almost a misnomer, it would seem, inasmuch as the central theme appears to be the deprecation of antisepsis in its relation, not alone to obstetrical surgery, but to general and gynæcic surgery as well.

Of his first definitions I have nothing to say, but after defining the relation of germs to infectious diseases he says: "Upon this hypothesis a system of prevention, not to say cure, of fleshly ills has been constructed. Whether or not this construction conforms to an actuality, whether or not one or fifteen . . . identified species of schizomycetes are proven to be the cause of one or more of the diseases (so called) that afflict our race, is a matter of *complete indifference*." In his next sentence he adds: "In either case it is the duty of homœopathists . . . candidly to consider its claim. Faithfully has this responsibility been met." Let us consider this: First, is the relation of germs to diseases (surgical diseases, mark you!) an hypothesis? An hypothesis is a supposition; something assumed for the sake of a conclusion; something assumed but not proven.

I must here apologize for making use of data with which the students of modern surgical pathology are already familiar, but the fact that such data are familiar and well founded entitles them to defence when assailed.

I do not think that Dr. Peck will deny that there are infectious diseases. Admitting this, as any intelligent person will, then it logically follows that there *must be infection*, and the communication of disease from one to another is common evidence that both of these propositions are true. Now, if we could go no farther than this, there might still be some excuse for regarding the microbic origin of disease as hypothetical. But we need not stop here. Bertoli, in 1859, speaks of tetanus causing the death of a bull, the flesh of which was eaten by slaves, in whom tetanus was likewise produced. In 1884 Rosenbach and Nicolaier discovered, simultaneously, the bacillus of tetanus, the former in the pus from a tetanic patient, the latter from the soil. Both of these investigators succeeded in isolating this bacillus, and by culture inoculation reproduced tetanus in lower animals. Eiselberg, in 1888, produced typical tetanus in rabbits by inoculation with cultures taken from the foot of a woman suffering from tetanus. Among the symptoms were increased irritability, trismus and pleurothotonous. Carle, Rattone, Airloing, Cornnevin, Thomas, Kitt, Flugge, Breumer, and many others have produced the disease by similar inoculations. In the year 1879 Neisser discovered the specific diplococcus of gonorrhœa. (*Centralblatt f. d. Med. Wissensch.*,

No. 28.) Bumm produced typical gonorrhœa by applying cultures of this gonococcus to the urethra in two females. Bokai reproduced gonorrhœa in two men by injections of pure cultures into the urethra. (*Allg. Med. Central Zeitung*, 1880, No. 74.)

Brockhardt made similar injections in a man suffering from fatal disease. At the autopsy a few days after, gonorrhœal urethritis, cystitis, and nephritis were found.

Welander also produced gonorrhœa experimentally, in a man, by urethral injection of gonococci. In all the above cases the discharges were teeming with gonococci.

The investigations of Smirnoff, Krause, Shuetz, Weiss, Lundstrom, and others are corroborative of the above. So also are the frequency, ease, and regularity with which the disease is transmitted from one to another of the human family.

The contagiousness of erysipelas has been admitted for centuries. It is now nearly ten years since Fehleisen discovered its essential cause,—the *streptococcus erysipelatosus*. With cultures of this he had no difficulty in reproducing typical erysipelas in both man and beast. Bachtinsky produced it in the same way in twelve patients suffering from diphtheria, all of whom recovered. Krause, Koch, and Gaffky have likewise reproduced it by inoculation with the same germ. So did Coley, of New York, only last year. Numerous others have done the same.

Doyen (*British Med. Journal*, 1888) has found the streptococcus of erysipelas in cases of puerperal fevers. So did Winkel, who cultivated the germs, inoculated lower animals, and produced typical erysipelas. And so I might go on, wearisomely amassing positive evidence that these and other diseases have specific causes, each one of which produces its own pathological lesion, subject, of course, to the modifications of mixed infection and individual idiosyncrasy. What is true of the above diseases is equally true of anthrax, glanders, suppuration, tuberculosis, itch, etc.

In the face of such evidence what room is there for an hypothesis? It has already been admitted that *there is a contagium*; then what can be more rational than to admit that the contagium is that which has produced disease, experimentally, hundreds of times, namely: germs?

Dr. Peck cannot deny that itch is produced by a parasite (there is no hypothesis about that); then why question the parasitic origin of anthrax, erysipelas, etc.? Everything in nature, as well as science, points to the impossibility of spontaneous development of infective

surgical diseases. "Ours is a world filled with countless varieties of life, these varieties in all probability related to each other—all living upon each other—everything devouring something and in its turn being devoured by something else—everywhere claw, beak, hoof and tooth—everything seeking the life of something else—every drop of water a battlefield—every atom a lurking place for some form of life or death." If there were no relation between germs and diseases 'twere almost a contradiction of nature, but Dr. Peck says, "Nature never contradicts herself." After the facts adduced there can be no more hypothesis in the microbic origin of disease than there is in the mydriasis produced by the injection of belladonna. The belladonna produces the mydriasis, it does not produce the salivation of mercury. The staphylococcus pyogenes albus produces pus, it does not produce hæmorrhoids, and the specificity of many isolated germs is shown by the fact that with inoculation and cultivation they reproduce themselves and their respective lesions through generation after generation. If experiments in this direction are occasionally negative I still maintain that the hypothesis does not enter, for homœopathy sometimes fails and yet Dr. Peck will scarcely admit that homœopathy "is constructed upon an hypothesis."

If I desired to select a physician who, above all others, was most liable to err in his estimate of the microbic cause of disease, "I know not the man I would so soon select" as he who says, "It is a matter of *complete indifference*." "It is the *duty* of homœopathsists . . . *candidly* to consider its claim." "Faithfully has this *responsibility* been met." Verily, there is a lesion in the logic of the man who tries to establish the relation of "*duty*," "*candor*" and "*responsibility*" toward that which is "a matter of complete indifference," and finally, if the belief in the parasitic cause of disease is as absurd, unreasonable and ridiculous as Dr. Peck would have it appear, then I thank him personally and professionally for the compliment he has paid a school of medicine among whose rank and file I am proud to be numbered, and four-fifths of whom, by his own admission, furnish no opposition or antagonism toward the germ causation of disease.

After dismissing parasitic ætiology, the "harmless absurdity," he takes up antisepsis, the "fashionable butchery." His method of finding out the status of our school in its relation to antisepsis is by no means infallible. Its chief merit lies in its vastness and originality. It is true that the majority of those who answered his com-

munications did not favor the employment of antiseptics. He concedes that antiseptics is a *surgical measure* and yet his conclusions in reference to it are based upon the statements sent him by general practitioners, who far outnumber the surgeons. How different would have been the result had the decision been that of the surgeons! I am far from disparaging the general practitioners (God bless them! How quickly we call them in when we are sick!) but it cannot be questioned that those of us who know little or nothing about the eye are not the best judges as to whether or not oculists should use glasses in the treatment of visual defects.

I do not wish to disagree unnecessarily with Dr. Peck, and therefore am glad that our ideas coalesce in the following: "Antiseptics implies moreover, ordinarily the employment of aseptic methods conjointly." Asepsis is good enough as far as it goes (as the fellow said of the parlor car when the axle broke), but it is a chimerical creature unless born of and nurtured by antiseptics. It is amusing to note the views of some who deprecate antiseptics and advocate asepsis only. All the time it is evident that they reach their asepsis by means of antiseptics in its varying forms. One of the greatest of antiseptics is heat and few of them fail to use it. Instruments and wipers are disinfected by heating, steaming or baking, hands are scrubbed and disinfected, perhaps with alcohol, and the operative field is also previously subjected to disinfection. Sutures and sponges have been immersed in antiseptic solution, the dressings have also been sterilized, or are antiseptic in themselves, and because the operator does not use germicidal material, applied directly to the wound surface, he disclaims all sympathy with antiseptics. Even Tait, the arch opponent, does not hesitate to subject his sponges to the most rigid disinfection. Such men are practicing Listerism in spite of themselves.

It is now eighteen years since Lister began with antiseptics, a measure that implies everything pertaining to the exclusion or destruction of infective influences, surgically considered. The underlying principle is the same to-day as when he began. Despite its modifications it is still Listerism. As analogy, Hahnemann believed that the thirtieth attenuation was as high as we needed to go for therapeutic potency, yet some of his followers prescribe the hundred thousandth potency. Regardless of this modification we are expected to admit that the law is the same in each case—that this is still Hahnemannianism, and it probably is, what there is of it.

I regret that in order to round out an argument I must here,

again, make cursory reference to testimony that is more or less trite. In 1864, the mortality rate from compound fractures ranged from forty to fifty per cent. Upon the introduction of Listerism (crude as it was at that time), among the various hospitals whence these statistics were compiled, the death-rate immediately fell to four per cent. Think of it! A saving of over forty human lives in every hundred suffering from this injury. Prior to adopting antisepsis, Volkmann lost his last twelve cases of compound fracture from wound infection. In his next series of one hundred and thirty-three he did not lose one.

Lister's death-rate was over forty-five per cent. in general operative work. His antisepsis at once lowered it to fifteen per cent. In some hospitals eighty per cent. of all open wounds, either accidental or operative, were attacked with gangrene. Erysipelas and abscesses were on all sides; nobody expected wounds to heal without suppuration; they were mighty thankful if they healed at all. Every wound, dressing, and draw-sheet was foul with pus, and there was rejoicing if it were the now obsolete "laudable pus," and the wounds escaped invasion by maggots. This was the age of surgical barbarism. The atmosphere was sick with the fetor of putrefying wounds. This condition represented the power and wisdom of the leading surgical minds of that day. A curse seemed to hang over the surgical world. Then, down through this pestilential surgery little antiseptic rivulets began to trickle—growing, gathering force, anastomosing and forming the beneficent river of Hope, the great surgical Gulf Stream, whose manifold influence has been felt almost by the world itself.

Listerism was a revelation as well as a revolution. If the crude methods at first employed were capable of producing such abrupt changes during those days of horror, how is it possible to estimate its benefit to humanity during the eighteen years of constant improvement? To-day it is more widely used than ever, and is still growing. How would those pre-antiseptic days suffer by comparison with the surgery of to-day—the surgery that has grown out of Listerism! One might go on endlessly giving evidence of what antisepsis has done in decreasing the death-rate, till many of our operators have less than one-half of one per cent., in major operations, and of what it has done in clearing even the charity wards of our hospitals from gangrene, while erysipelas and suppuration are almost unheard of in operative wounds. The very measures that have brought these changes are once more assailed, and we are asked, contemptuously, by what authority we are "educated up to such an eminently rational and scientific procedure?" These very measures

Dr. Peck's paper speaks of as "poisonous" and "dangerous." Does this look as though they had been "scrutinized with strict impartiality," as he states? The element of danger must, indeed, be small in that which has produced so much good. The greatest phantoms have sprung into existence without any parentage save fear and innocence. If these procedures had been "scrutinized impartially," would antiseptics have been considered in the same connection with Brown-Séquard's elixir and Koch's lymph? It is true that these and other therapeutic vagaries are dead, while over them, with the corners snugly tucked in, is spread the motley four-ply mantle of oblivion; but antiseptics is active, efficient, and still growing, after eighteen years of constant use. Measures are good or bad according to their consequences; and after showing, but too briefly, what Lister's measures have done, how shall I characterize those who speak of them as consisting of "crude," "irritating," and "poisonous solutions," of "their slaughtered victims;" who say that the endorsers of such measures are "mummified dispensers of fossilized lore?" It would not be in accordance with my idea of propriety to term this ignorance; rather let me say it bespeaks an unfamiliarity with modern antiseptics; but after such an exhibition of unfamiliarity what becomes of the "impartial scrutiny?" When a writer is secure in his position he can afford to be good natured; weakness is often malicious, and when argument fails passion comes to the rescue. Kindness, candor, the spirit of investigation (with encouragement to others to develop the same) are professional virtues.

We are not all antiseptic cranks. We try to be reasonable. It is results that drive us to antiseptics. For my own part (although many of the lay people who read the best class of current literature are beginning to demand antiseptics from their surgeons) I would be glad if it could be shown that its omission would be justifiable, for its details are numerous and wearisome. On this account a careless or lazy man will never make a good antiseptician; he lacks the "surgical conscience."

It has never been quite clear why antiseptics should be branded as dangerous. May I be pardoned the personal allusion, if I say that the reason for this is that I have used antiseptic solutions (bichloride *e. g.*) in the uterus, bladder, bowel, abdomen, pharynx, eye, interior of eyeball, and brain, etc., without causing any noticeable irritation, and I am far from believing that I have a tithe of the skill possessed by hundreds who remain silent while ridicule is heaped upon the men and methods that have civilized surgery.

One of the gentlemen from whom Dr. Peck quotes (to show what

a dangerous thing antisepsis is) says: "With my first three hundred (labor) cases, while practicing under the allopathic system and all its tomfoolery of asepsis and antisepsis, I was in hot water all the time." Shades of all that's shadowy! What kind of antisepsis (?) can it be that is capable of producing, successively, three hundred complicated labor cases? It has already been said that methods are good or bad according to their consequences. The methods capable of accomplishing the above feat are not those that we advocate—*abusus non tollit usum*. When a drug becomes remedial it ceases to be poisonous; much then depends upon its method of application. Soap sometimes irritates the skin, but a good share of the world continues to use it, and individual indiscretion and idiosyncrasy are weak arguments to bring against it. Away with the back-handed philosophy whose chief aim is to build up, against every great goodness, some counterbalance of badness, either real or imagined.

The physician who has a series of three hundred complicated labors admits too much. I admire his candor, but deplore his caution. Let me cite a case: Mrs. A., æt. 30. She had had four miscarriages and was threatened with the fifth. During each previous illness her life was despaired of on account of puerperal sepsis. The same physician attended her each time, and consulted me with reference to the miscarriage then threatening. "He could not understand how the sepsis occurred, because he had treated the case antiseptically." I knew the man; he was not only careless, but dirty. I knew that he washed his hands once with each seance, and that was after he had completed his task. In other words, he took the placenta from the uterine cavity with black finger nails, and his antisepsis consisted of douching the vagina. He was therefore, advised in the pending miscarriage, to give the patient time and not to touch her with his fingers nor to examine her if it could possibly be avoided. The patient miscarried and made a prompt recovery for the first time without puerperal sepsis. Is it any wonder that *his* patients do better without *his* antisepsis? As the Greeks says, "In the presence of such stupidity the gods stand helpless."

Many physicians who say they never have any puerperal fever in their practice admit that their lying-in patients sometimes suffer from malaria. We have not infrequently curetted the uterus, in such cases, and extracted putrid placental shreds, and with them the "malaria" (?). How often are chilly creeps along the spine and the flushed face of sepsis diagnosed malaria?

Dr. Peck expatiates at length upon antisepsis, and, finding little help from his logic, he appeals to the laboratory and quotes from

three bacteriologists, whose opinions are adverse to germ infection and antiseptis. Surely, the great mass of accumulated testimony from thousands of clinicians and bacteriologists cannot be overthrown by the opinions of these three savants. Even if germs are not the cause of wound infection, as one or two of these scientists seem to think, antiseptis is still sound by reason of its clinical results—exactly the same food upon which homœopathy has thrived. What Hahnemann was to medicine, Lister was to surgery.

As further evidence against germ infection and Listerism, a physician is cited who, with eighteen years' experience, has treated confinement cases in the same room in which an erysipelas patient was lying, without bad results. This testimony is *outré*, to say the least. The man who has been in practice eighteen years and still has a parturient patient and an erysipelas patient in the same room is not the safest example to quote. He might also have mentioned the men who slept with a small-pox patient without contracting the disease. That does not disprove the infectiousness of small-pox. It takes more than one explosion to make a Fourth of July.

That kind of obstetrics is responsible for much of the concentrated agony of maternity. That kind of obstetrics, with the sparks beneath its nails to light the fagots of puerperal pyrexia, is the running-mate to the gynæcology that repairs its complete perineal ruptures with calendula lotion and a towel around the thighs. That kind of obstetrics should go hand in hand with the surgery that for ages was stagnant, motionless, save for the writhing of the maggots in its wounds—the days of surgical blight, when the obstetrician stood bewildered, mocked by that invisible monster, Infection—that thief of human flesh, robbing the parturient couch of its fruit, or, more frequently, tearing the mother from her first-born ere the laughing dimples upon its infant cheek had been smoothed by the velvet touch of a mother's farewell kiss; when in many places fifty per cent. of the babies were born only that their mothers might die; when conception and sorrow were synonyms. Yet the methods that have dispelled these horrors, the methods that immediately lowered the death rate in confinement to two per cent., and since then to one-half of one per cent., and in some places to *nil*, have been termed "allopathic tomfoolery." Shame! Listerism is no longer allopathic. It has long since burst the narrow confines of schools and now belongs to the world. The light that Lister shed was the first, the brightest star that ever glittered through the midnight of surgical despair.

CHAMPAGNE AND DIABETES.

BY CLIFFORD MITCHELL, M.D., CHICAGO, ILL.

(Second Paper.)

IN my first paper I showed that the healthy person may drink sugar-rich champagne and yet void urine in which no sugar can be found by Haines's test; on the other hand, that I had found sugar by Haines's test in the urine of a certain patient only after drinking champagne.

Now comes still another patient who says that his physician has found sugar in his urine; examining the urine of twenty-four hours I find no sugar at all with Haines's test, not even a trace on cooling in either the total day urine or the total night urine. Analysis of his urine, however, showed the following:

Total day urine,	850 c.c.
Total night urine,	315 c.c.
Ratio of day to night,	2½ to 1
Urea, per liter,	28 grammes.
Urea, per fluidounce,	13 grains.
Urea, per 24 hours,	33 grammes.
Urea, per 24 hours,	515 grains.
Phosphoric acid, per liter,	3 grammes.
Phosphoric acid, per fluidounce,	1½ grains.
Phosphoric acid, per 24 hours,	3½ grammes.
Phosphoric acid, per 24 hours,	55 grains.
Specific gravity, per 24 hours,	1032
Reaction,	strongly acid.

Here was a case then in which the urinary solids were relatively increased compared to the urinary water; in other words, the specific gravity was higher than normal.

He was requested again to collect the urine for twenty-four hours, that of each micturition being collected and bottled separately, a glass of sugar-rich champagne being drunk on an empty bladder before retiring. This was done, and on testing the urine of each micturition I found no sugar at all in the urine voided *after* drinking the champagne, but a plain trace in one of the samples of day urine voided *before* any champagne or other sweet drink had been taken. Questioning him as to diet he said that he had eaten a *banana* before voiding the urine in question. The experiment was then repeated precisely as before; this time abundance of sugar was found in the urine voided after digestion of the noonday meal, but none at all after taking the champagne at night nor at any other time.

Being questioned again as to the character of the noonday meal,

he said that among other things he had eaten *sweetened rhubarb*. Three drops of his urine now gave a greenish precipitate with Haines's solution and six a light yellow. The specific gravity of the urine containing the sugar was 1035.

Inasmuch as sugar was found both times in the urine voided after the mid-day meal, he was now requested to collect the urine again, but to drink his champagne with the mid-day meal, instead of at night, and to omit fruits and vegetables. He now ate for his lunch bread and meat only, drinking two glasses of champagne. Eight drops of his urine voided afterward showed a plain trace of sugar with Haines's test on cooling: six drops showed nothing at all at first, but in an hour showed a trace.

This case confirms the results of previous observations which I have made to wit: that *the urine voided after the noon-day meal* will sometimes contain sugar when the latter can be found at no other time of day.

In this particular case champagne at the noon-day meal had less effect on the urine than sweetened rhubarb and no more than one banana, though it is of course possible that other and unknown factors changed the quantity on the different days.

It would appear, therefore, that the tendency to occasional presence of sugar in the urine depends, in some cases, first upon the time of day and second upon the ingestion of certain saccharine articles of diet; lastly, that a sugar-rich champagne may cause less sugar in the urine than certain sugar-rich solids.

In using the champagne test, then, for the early recognition of a tendency to occasional glycosuria it is well to have the patient drink it at noon and to test the urine voided after the noon-day meal; if the test fail, to have recourse to saccharine solids. Any patient who voids urine habitually over 1030 in specific gravity for 24 hours, while on ordinary diet should be subjected to close scrutiny in order to detect a tendency to occasional glycosuria. Every one knows that sudden death may take place from diabetic coma, when the presence of sugar has been recognized but for a few days or hours. I have no doubt but that occasional glycosuria is more common than is generally supposed and that it precedes, perhaps, by years the establishment of real diabetes.

It should be said in concluding that the patient spoken of in this paper shows no sugar in the urine after the noon-day meal when the diet is meat and bread and butter only, without purely saccharine food or drinks.

THE DIAGNOSIS AND TREATMENT OF EXTRA-UTERINE PREGNANCY IN ITS LATER STAGES.

(With a presentation of specimens from a case successfully terminated by abdominal section at eleven and a half months, in addition to a number of other specimens.)

BY THEODORE J. GRAMM, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

AMONG the recent advances in medical science, there are none more entitled to our gratitude and admiration than the possibilities and achievements of modern gynæcology; and of all the intra-abdominal or intra-pelvic conditions thereby made amenable to successful surgical interference, there are few which compare in interest with that of ectopic gestation. This curious condition brings about an illness having sometimes a tragic termination with appalling rapidity, or it entails months of mental and physical suffering upon its unfortunate victim.

It may appear that subjects like this, while having much interest for the specialist, have little or none for the general medical man. Yet there is no knowing how soon any one of us may be confronted by a typical case. Our next apparent case of incomplete abortion may be really one of ectopic gestation, or our next obstetric case may be one which can only be successfully terminated by the babe passing *over* instead of *under* the pubic arch, by virtue of not being within the uterus at all.

At the very outset, therefore, I wish to emphasize the fact that while the correct treatment is often surgical, and by men of large experience is said to be mostly such, yet the diagnosis is almost always first demanded of the general practitioner. Indeed, one has not to go far in examining the literature of this subject to meet with accounts of general practitioners having, with great nicety, recognized their cases, becoming thereby entitled to much honorable consideration.

That the diagnosis of ectopic gestation is possible, is demonstrated by innumerable recorded instances; that it may be difficult, will probably go without saying; that the diagnosis may not be invited on account of the patient not coming to a physician until suffering from urgent symptoms, is of frequent occurrence; but, as pointed out by Strahan and experienced by myself in the cases of which it has been my good fortune to have personal knowledge, the main

point concerning the diagnosis, and one of transcendent importance, is to realize the fact that extra-uterine pregnancy occurs, occurs frequently, and may exist in the particular case in hand. The fact that the mind has not been receptive to the possibility of extra-uterine pregnancy has, without doubt, been the cause for many an otherwise good diagnostician failing in the supreme case in his medical career. This unpreparedness of mind finds its probable explanation in the belief formerly more prevalent, that extra-uterine pregnancy is of infrequent occurrence,—a view demonstrated to be incorrect by abdominal surgeons who operate frequently and who subject their specimens to rigid examination. It is with comparative frequency that they find the evidences of early ectopic pregnancy during operation, or discover conditions which admit of rational explanation according to no other circumstance. In addition, it is quite likely that many obscure cases, coming only to medical men and not elucidated by abdominal section, but which, after protracted illness, make a partial or complete recovery, are really the subjects of this singular accident.

As has been said, the diagnosis is possible. On the other hand, many mistakes have been made, and that, too, by men of much skill and wide reputation. If any, therefore, have failed to recognize their case of ectopic gestation, they may lay this flattering unction to their souls, that they have erred in what may be considered to be pretty good company. On the other hand, the thought obtrudes itself that the oft repeated assertion that grave errors in diagnosis are made only by those who give a partial or complete adherence to the therapeutic law of similars, is not borne out by the historical occurrences associated with the recognition of extra-uterine pregnancy.

The varieties of ectopic pregnancy which may occur have furnished the subject for warm discussions, and many writers have published "schemes" of varieties thought to exist. That this subject, as yet unsettled, should receive attention seems self-evident, and when properly determined will probably explain those cases exhibiting no symptoms or varied symptoms, and will probably facilitate their recognition earlier than the advent of lethal states.

The scheme proposed by Tait, while being essentially different from most published, commends itself because of his vast experience with actual cases upon which it is based; because of its attractive simplicity according to which many cases are capable of rational explanation; and mainly on account of the prominence given to that variety, of which the largest number of cases occur. Wherein Tait's

views differ from those of most authors who have approached the subject, is in his entire denial of the occurrence of primary abdominal pregnancy, and in his disbelief in the occurrence of ovarian pregnancy. He holds to the view that most if not all cases are originally tubal, rupturing upward when the placental attachment is so situated and producing intra-peritoneal hæmatocele, or rupturing downward into the broad ligament furnishing intra-ligamentous hæmatocele and the cases of advanced foetal development; or the ovum is extended through the fimbriated extremity of the tube and ultimately involves neighboring organs. These are the views of a much-abused man but one whom an exceptionally large experience in abdominal surgery justly entitles to consideration. That they are correct as to the varieties most frequently occurring, all observers admit. With regard, however, to what he denies or doubts, there is not such unanimity; and yet a provisional acceptance of his scheme seems to be the correct mental attitude to assume, until many more cases have been observed, and have been reported with considerably more care and associated with much more evidence of a knowledge of the morbid anatomical changes taking place. The inference that cases have not been observed with care nor reported in conjunction with the evidence of a knowledge of attending morbid changes, will find its justification if any number of cases be carefully scrutinized. I would make an earnest plea for careful observation of operated cases of every variety of abdominal disease, and a far more minute and elaborate statement of observed conditions. This whole subject will no doubt be much further elucidated when we possess a more certain knowledge of the relationship existing between menstruation and ovulation, and also concerning the locality where impregnation usually occurs and where it may take place.

Ectopic pregnancy presents itself for diagnosis under several very widely different conditions; and it is just this fact which must be borne in mind, for in each period of its history it presents a different picture. A familiarity with these phases is absolutely necessary, or the diagnosis, difficult at best, will be missed. The history of its evolution divides itself naturally, as most authors have viewed it, into three stages, *i.e.*, before the foetal heart is audible; after it may be heard and until death of the foetus; after the death of the foetus.

The vast majority of cases are seen while in the first stage, and progress through a variable portion of that time. In the early part of the first stage, and before primary rupture, the diagnosis is diffi-

cult and uncertain. It is so mainly because few if any symptoms show, and no occurrences have so far attracted the attention of patient or physician. Should an examination be made a tubal enlargement or occlusion, a semi-fluctuating and highly sensitive mass would be felt beside or behind the uterus. Let us therefore remember in our every-day pelvic examinations that a mass felt laterally may be something far more than salpingitis, hydrosalpinx, tubo-ovarian inflammation or parametritis as it has been called. If this fact be constantly before the mind in every-day work an important step will be taken toward properly interpreting any anomalous occurrences which subsequently transpire. In attempting to diagnose this condition it readily becomes apparent that no one or two symptoms can be relied upon to establish the diagnosis. Indeed it is difficult to recall any diseased condition of which it may be more truly stated that it is only in the aggregation of symptoms, subjective and objective, that the condition may be recognized. Any one of these signs, however, should serve to attract attention, and then it may be delightful to see how the other symptoms and signs presented fall into line and establish the diagnosis, or supposing the case less easy, a far more careful examination will be made and the case watched over a longer time.

It was my original intention at this point to review the symptoms which occur during the early stages of ectopic gestation, but interesting as that would be, and indeed necessary as a correct appreciation of their relative value is for the diagnosis, yet this subject must be left for a future occasion. For the present it must suffice simply to name those symptoms which occur with a certain degree of frequency, any one of which or combination of several should always attract attention. They are :

Previous inaptitude for conception.

Atypical metrostaxis.

Early symptoms of pregnancy.

Colicky pains in lower zone of abdomen, especially sides.

At twelfth week symptoms of rupture, *i.e.*, violent pelvic pains without apparent cause ; syncope, and symptoms of internal hæmorrhage.

Recurrent attacks of these symptoms.

Decidua passed in shreds or whole.

Impaired function of bowels and bladder.

Annular stricture of the rectum.

These symptoms, let me repeat, are not constant either individu-

ally as stated nor in association, but are subject to very marked exceptions which lack of time at present prevents reviewing.

Should the fertile ovum not perish at the time of the rupture of the containing sac, it may go on developing within the folds of the broad ligament for a variable length of time when secondary rupture into the peritoneal cavity may take place, attended by all the symptoms of intra-peritoneal hæmatocele. At this secondary rupture the ovum usually dies as it also does when the primary rupture has taken place into the peritoneal cavity. Then the remote termination of the ectopic gestation is associated with that of the hæmatocele. If the ovum does not die at the secondary rupture, the so-called abdominal pregnancy occurs.

The ovum may die at any period of its development even in its extra-peritoneal location. The liquor amnii is then absorbed and the solid portions of the fœtus remain within the broad ligament to form ultimately a lethopædion; or the contents of the cyst may suppurate and form a pelvic abscess. This abscess ultimately tends to discharge, and does so through the rectum, vagina, bladder or through the abdominal wall. Tait has pointed out that the fact of these abscesses discharging in the manner and in the order named proves his views of the pathology. The history of such a case when it terminates in a pelvic abscess, is usually of little assistance, and comprises only obscure data of pelvic trouble. The nature of many such cases has not been recognized until a fœtal bone was found protruding from the fistulous opening.

Should the fœtus go on developing toward term, its presence, though ectopic, excites similar symptoms as in normal pregnancy. When the fœtal heart sounds become audible, which is variously stated to be from the eleventh to the eighteenth week, the fact of pregnancy is established, and an important feature of difficulty is eliminated from the diagnosis.

If the ectopic character of the pregnancy has not been recognized until now, another opportunity may not be given until term, for the course of events may be unincidental, and fail to attract attention. There are certain symptoms though, which should be observed with care: such as deeply seated pelvic pains; violent and painful fœtal motions felt only on one side; fœtus lying superficially; loud circulatory sounds in the abdomen; atypical uterine hæmorrhages, accompanied by discharge of fragments of decidual membrane. The decidua may be retained until or after the supervention of spurious labor and the death of the fœtus.

This spurious labor occurs quite uniformly, and is certainly a curious and interesting phenomenon. It consists in the advent of more or less regular pains closely simulating normal labor. It is said to be attended by violent foetal movements, and certain it is that the foetus dies about this time. If there has not recently been a metrostaxis, it will appear now.

At this period in the history of the case, some physician usually is given an opportunity of diagnosing it. On examination the abdomen may present nothing abnormal in appearance; often the enlargement seems to be all or mostly on one side, or instead of being oval the transverse diameter may be greater than the perpendicular or the outline of the abdomen is irregular, made so by foetal parts projecting and forming irregular prominences where normally there should be none. The foetal motions may be distinctly visible, and on palpation be readily recognized. Besides this general change in outline and the smaller irregularities caused by foetal parts, there is another projection which is often visible, and which has been admirably pointed out by Parry in his classical work, namely that caused by the greatly enlarged uterus. This may appear in the hypogastric region or in the lateral regions above the pelvis. This prominence can be accurately determined by careful palpation at any time subsequent to the period when the foetal sac rises above the pelvic brim.

Vaginal Examination.—Here the usual conditions existing in normal pregnancy may be discovered; that is to say, elevation of temperature, pulsating arteries, and a congested and bluish appearance of the mucous membrane, as pointed out by Fry.

In the cervix the most striking abnormalities are manifest. In the earlier months it will be found soft and velvety, enlarged, and the os occluded by a plug of mucus as in normal pregnancy. A little later, that is, after the fourth month, these changes will be found not to have progressed in proportion to the time of the pregnancy. As compared with what it should be, it will be found more firm and smaller and not to have undergone the decrease in length nor the usual commencing involvement in the general uterine ovoid. Nearing the normal time for delivery, the cervix is elongated (which is very important), softened and patulous, admitting the index finger along the canal up to the internal os.

Besides these changes from normal consistency, there is a striking abnormality in the position of the cervix, one frequently observed and which cannot fail to be noticed. In a certain number of cases the uterus is crowded down in the pelvis, when the cervix will

be readily found lying near the vaginal outlet or pushed against the sacrum. Mostly, however, it cannot be found at first, and only after an extended examination will it be discovered high up in the pelvis almost out of reach, and usually to one or the other side. Realizing the fact that an upward displacement of the cervix often occurs in normal pregnancy by reason of a marked anteversion of the fundus, the fact yet remains, that if nothing else revealed by the vaginal examinations attract attention, this marked displacement of the cervix always should do so. Especially should this be the case when found in conjunction with the changes in consistency and shape just named.

On bimanual examination the fundus uteri may not be found, nor, when discovered, be seen to be much enlarged. This enlargement is often not globular, but the fundus is flattened antero-posteriorly.

Later on this deviation in shape will not be so well marked, but its shape will be more pyriform. It may happen in the later months that should the cervix be much softened and elongated, both in its intra- and supra-vaginal proportions, that considerable difficulty may be experienced in demonstrating the connection between this flabby cervix which the intra-vaginal finger touches with some difficulty, and the pyriform body which is seen and felt above the pelvic brim within the abdomen. To the truth of this I can testify from personal experience, and the difficulty existing in my case, which has been published in the *American Journal of Obstetrics*, vol. xxv., No. 2, may explain the failure of other physicians who examined the case prior to myself. On that occasion an application of the methods attributed, I believe, to Martin, which I habitually employ in all doubtful cases, stood me in good service. I may also say, that what I believe to be a perfecting of these methods by using the corrugated tenaculum devised by Dr. Howard A. Kelly, and in the manner suggested by him, greatly facilitated the examination. The methods referred to consisted in producing an artificial and temporary prolapse of the cervix and uterus at the same time that the lateral regions of the pelvis and sides of the uterus are examined. I have often heard physicians say that they use the vulsellum forceps, which are just as good, but any one trying the modifications just named, and which I cannot longer stop to describe at this time, cannot fail to realize their great superiority.

Another point is of interest. This pyriform body or smaller globe, as it may appear to be, which is so often felt near the larger ovoid

of the fetus, should be carefully palpated by one hand lying gently upon it. It may then be found that picking it up or kneading it gently, and then ceasing all motion, that this body changes greatly in consistency and becomes much more firm. It may become more prominent and its outlines more defined. In other words, it will be found that a definite contraction of the uterus may be induced and felt. If this examination be made with care and concentration of mind, valuable evidence of an empty uterus may be obtained. If it be not done with care, a contraction may truly be felt, but its limited extent and its clinical significance will be lost, since the normally pregnant uterus may be made to contract in a somewhat similar manner, and the same has been said of the foetal sac.

Besides these methods of examination, the uterine sound has been used for diagnostic purposes. It is probably not surprising that by the use of this instrument premature delivery has been unintentionally induced in cases where the pregnancy proved not to be ectopic. Harm has likewise been done by presumably skilful men in extra-uterine cases by perforating the fundus. The facility with which this may be done is surprising, but can be appreciated if one has had the opportunity of examining such a uterus, or one in an analogous condition. In my operated case the uterine tissue was very soft and friable and would scarcely hold a stitch. On the other hand, if the requisite care be employed by a hand accustomed to pass an instrument along tortuous passages, the sound or a sterile catheter may be made use of, always bearing in mind the readiness with which damage may be done. I should say, however, that in view of the much greater utility of a careful bimanual examination, especially in the manner above described, that the sound should only be used after the application of other methods, and to confirm the results obtained by them.

Examination per rectum will verify the physical signs above mentioned, and in addition will often demonstrate that a separation exists between the rectum and the vagina not normally found; while this space will be occupied by new formed soft tissue, or by foetal parts which may be palpated with astonishing facility.

In conjunction with these changes which have been effected by the ectopic position of the fetus, the mammae will be found to have undergone the corresponding and well known changes of normal pregnancy.

In regard to treatment, not much need be said at this time, especially not of the treatment of that stage to which the major portion

of this paper has been devoted. Abdominal section and the removal of the offending infant is now pretty generally acknowledged to be the correct procedure, the only questions being when and how the operation should be done.

In the earlier stages the treatment is regarded as more debatable. At the time of rupture, in view of the advanced position of intra-abdominal operations and their splendid results, the case should be viewed in but a single light. It should be determined whether hæmorrhage has taken place into the peritoneal cavity, either by rupture or extrusion through the tube. If such be the case, the well known surgical principle to cut down and tie the bleeding point holds good as truly within the abdominal cavity as in any other part of the body. The operation should be undertaken as soon as possible, and in its performance every effort should be directed undeviatingly toward the one object of finding the bleeding point and placing a ligature upon it.

Should the hæmorrhage have taken place into the broad ligament and the symptoms of collapse be less urgent, less decisive action may be sufficient. The case should be watched with the greatest care and proper remedial measures applied, associated with absolute rest in bed. Indeed, in accordance with the views expressed in a very instructive article by Dr. H. T. Byford in the *American Journal of Obstetrics*, vol. xxiv, No. 11, page 1292, many more cases of ruptured ectopic pregnancy occur than is supposed, and a rational treatment is followed by admirable results. However let us not temporize in unwarrantable cases, nor assume the fearful responsibility of a fatal termination of what might have been a useful life.

In the stages later than that of rupture, when the fact of ectopic pregnancy is established, opinion is divided as to the treatment. Formerly puncture of the sac, the abstraction of the amniotic fluid, the injection of poisonous or irritating substances was advocated, and prior to the application of the antiseptic method in surgery there may have been some excuse for such methods. Now, it seems almost needless to say there is none, nor will the mind long remain in doubt after reading an account of some of the horrible procedures used in the furtherance of these views.

There is, however, another method of treatment, reliance upon which I name only to condemn,—a method which may be regarded as an inheritance from an era in surgery now long since superseded by a better. I refer to the use of electricity for the purpose of destroying the life of the child. It seems to be a matter of regret that some

splendid names are connected with this procedure; but from free discussion the answer to the question seems to be rapidly crystallizing into the truth.

Specimens Exhibited.

1. Full grown fœtus from a case operated by myself at eleven and a half months.
2. Microscopic slides and fragments of placental tissue from same case.
3. Microscopic slides and fragments of fetal sac from same case.
4. Microscopic slides and fragments of decidual membrane for same case.
5. Specimens of ruptured tubal pregnancy loaned by Prof. B. F. Betts, comprising uterus containing decidua, uterine adnexa, one tube showing site of rupture and ovum.
6. Decidua from another case, loaned by Prof. Betts.
7. A plate showing microscopic structure of decidua, from library of Prof. B. F. Betts.
8. Specimens from a ruptured tubal pregnancy from the Museum of the Hahnemann Medical College, loaned by Dr. R. B. Weaver. Uterus contains decidua, one tube admirably shows site of rupture.
9. Specimen from Museum of Hahnemann Medical College loaned by Dr. R. B. Weaver, *i.e.*, fetal bones from a case of Dr. Bullard (published in Pennsylvania State Society *Transactions*, 1888), which were discharged through rectum.
10. Specimens loaned by Dr. W. H. Somerville for a case also seen by Prof. B. F. Betts, comprising many fetal bones discharged per rectum after being retained for nineteen years.
11. Ovary and tube (not yet examined microscopically) for a case operated by Dr. W. B. Van Lennep, which presented all the evidences of ectopic pregnancy at the time of operation.
12. Microscopic slides from a case of over ten months, operated at Johns Hopkins Hospital, consisting of: fetal sac containing ovarian tissue; fetal sac containing placental tissue; fetal sac containing fallopian tube.

STRONTIANA CARBONICA IN DYSPEPSIA.—Dr. Weisz has used *strontiana carbonica*, for several years, with success, in the treatment of a certain form of dyspepsia, when such drugs as *natrum muriaticum*, *natrum carbonicum*, *magnesia muriatica*, *nux vomica*, etc., fail. It is easily soluble and highly alkaline. The form of dyspepsia in which strontiana carbonica is appropriate is chronic; the patient is emaciated, has an anæmic look, and often suffers from cramps in the muscles and feet. These appear especially after going to bed as well as when the patient stands upon an iron plate or even when he touches a nail with his foot. One patient who was cured with this remedy was unable to cross an iron bridge of 150 feet length, without being seized with cramps in the calves of his legs as well as his feet. The stomach trouble is characterized by continuous and violent pressive sensation during digestion, associated with heartburn and eructation of a sour watery fluid as well as with occasional sour and bitter vomiting. These are accompanied with hemorrhoids, constipation and gastric headache.—*Leipziger Populäre Zeitschrift für Homœopathie*, No. 3-4, 1892.

FERRUM PHOS. is useful in the beginning of hydrocephaloid, in a violent attack of summer complaint the child becomes drowsy and heavy, its eyes suffused with blood and a full soft pulse.

EDITORIAL.

THE AMERICAN INSTITUTE.

THE President of the American Institute of Homœopathy, in his annual address at Washington, called the attention of the members to some of the dangers lurking in the pathway of the Institute. "I earnestly advise extending the time limit of our annual sessions" is one of his suggestions; and if this advice is taken and acted upon in earnest good faith, the Institute will be safely conducted around a dangerous boulder that is now threatening the very existence of our national association. Homœopathy in America is no longer a specialty of medicine. Force of circumstances has created, under its domain, a great school of medicine, with practitioners numbered by thousands. This fact being acknowledged, and this being the day of specialties, it is not surprising to find within our ranks a large number of men and women who devote their entire time and energy to the development of some special branch of practice to the exclusion of direct interest in general medicine. Their whole force is thrown to surgery, to gynæcology, to ophthalmology, etc., and here their interest centres, no matter how intense their loyalty may be to the general welfare of the national organization. These specialties embrace many of the brightest and most indefatigable workers of our school; and the utterly inadequate provision that has been made of late years for the presentation of their essays bearing upon the results of their personal research, experiment and practice, and a profitable discussion of the same, has chilled the ardor of some of the ablest pens, and created an undercurrent of restlessness that is rapidly crystallizing into positive opposition to the Institute's recent policy.

An Institute bureau is composed of five to fifteen members. The chairman naturally selects his associates from members who are well known to be especially proficient and aggressive in the particular line of work of the bureau. These members, knowing that they are the picked leaders for the next sectional meeting, devote their best thought, time, and experience to produce an essay of value for the members interested in this special branch of medicine. For ten members to prepare and present essays is by no means an unusual occurrence, and the three or four hours' time that is usually provided for the bureau to present, read, and discuss these essays, which

have taken hours and hours to produce, and whose writers have come hundreds of miles to present and defend, is so absurdly inadequate, the wonder is that rumors of rebellion and expressions of intention to cut loose from the general association and form American societies of specialists, have not been far more general. However this may be, the danger is apparent, the condition is present, and it will require skilful handling, or the opportune time to hold these diversified interests to the parent organization will be lost. Already the obstetricians have formed a distinctive society, to which they give their best thought and effort, knowing that their labor will here be fully appreciated and will receive the consideration that is rightly its due. There is nothing so utterly demoralizing to an essayist as to have a chairman interrupt with the plea that the time is insufficient to allow the completion of the paper and a free discussion.

The surgeons have long since felt the full force of this unjust time limitation, and have organized an American association of surgeons, and they are fully prepared to assume and maintain a separate and independent existence. What is said of this group of specialists holds good for all other branches of the profession, the difference being one of degree only.

The loss of unity of sympathy and action of its members will hopelessly wreck the usefulness of the Institute. The root of the evil is dependent upon the fact that the time allotted for bureau work is insufficient, and is not commensurate with the importance of the work in hand. The president recognized the difficulty and wisely pointed the way to its solution, and the Institute quickly adopted the suggestion, but unfortunately delayed putting it into immediate operation, and aggravated the trouble by abolishing altogether the bureaus for 1893.

It is greatly to be regretted that the wisdom of the leaders of the Washington meeting led them once again to relegate the American Institute of Homœopathy to the rear to serve as a tail to a so-called International Congress.

Much against the judgment of an influential minority, the Institute abandoned its distinctive function last year and yielded supremacy to the Atlantic City Congress. Of course, nothing succeeds like success, but why the experiment should be repeated in two years, we have yet to hear a legitimate reason. The World's Fair is an American undertaking, to which all the world is invited, and it will be a genuine American success. This is what the world is

coming to see. The homœopathic polity of Europe is widely different from that of America. In the Old World, homœopathy is still a therapeutic speciality. In America, it represents a school of medicine embracing every known speciality. Our foreign *confrères* will come to America as the guests of the American Institute, and will naturally expect to see American institutions. It is certainly a mistake to abandon the distinctive features of the Institute, and try to convert it into a congress or convention patterned after the Anglo-Franco-German order. America is the Mecca of homœopathy, and its American characteristics should be preserved.

SIR ANDREW CLARK ON PULMONARY TUBERCULOSIS.

IN the first of a series of lectures on fibroid phthisis, published in *The Lancet* for July 2d, Sir Andrew Clark has again demonstrated his right to the reputation of being one of the most independent and profound thinkers among English medical men. In this case, as in many others, he speaks in telling words, and we trust that his ideas will receive general acceptance throughout the profession the world over. The doctrines advocated in the lecture referred to are those that have been held by homœopathists for many years. We proceed to give them in detail without further comment.

Sir Andrew pays a glowing tribute to Koch's brilliant researches, showing that in phthisis tubercle bacilli are always present; that they were capable, through inoculation, of producing tuberculosis in animals, and that the tuberculosis so produced could be propagated downwards for several generations. The disease produced by inoculation is, however, acute tuberculosis, and there is not conclusive evidence to show that the disease which our lecturer defines as phthisis is ever so produced. Sir Andrew does not deny that there is any relation between acute tuberculosis and phthisis, but he contends that there is a fundamental organic difference between the conditions of which they are the expressions. Continuing, he says "there are factors in the evolution of tuberculosis,—the tubercle bacillus and the soil on which they grow. For it is certain that the tubercle bacilli will not flourish in every soil, and that the soil which at one time has favored their propagation will at another time cease to do so."

Concerning tuberculin and other similar agents which have been tried with the view of destroying the bacilli, Sir Andrew says they have failed to produce one authentic cure of a case of phthisis. The

more he studies the phenomena of phthisis, the less, he says, "becomes his expectation that any agent will be discovered by which the tubercle bacilli will be killed and the progress of phthisis stayed."

"Phthisis does not consist in any specific action of the bacillus or of the products of its living action. It consists in the reaction and in the nature and character of the reaction of the tissues of the organism to the irritations which the bacilli and their products create. Now, organisms are different, and they often respond very differently to the same irritations, and thus it happens that these tubercle bacilli give rise to products of irritation and therefore forms of phthisis which are different from each other, which have their origin in different state of constitution, which have a different assemblage and progression of symptoms, which respond differently to their environments, which pursue a different course, and which issue in different structural results."

The lecturer next proceeds to show, that according to the nature of the "soil" the bacilli implanted in the lungs produce fibroid or pneumonic changes, and according as one or the other of these dominates, the course of the disease varies. In still other cases the bacilli produce no pathological changes. This being so, he pertinently asks, "would it not be infinitely better for us to spend less of our time in what seems vain attempts to destroy these microphytes and more of our time in studying the character of the soil in which they will or will not grow? For all my experience points to the conclusion that it is mainly, if not entirely, through the influences which we may be able to exert upon the soil that we may best control or stay the progress of phthisis."

Next, the words "scientific retrogression" in italics and heading a paragraph greet our eyes, and we read: "Now, as the structural products of tubercle bacillary irritation in the lung vary in form and structure, and as each variety has a different life history from the other, and as these life histories are most diverse, I regard it as a most scientific retrogression to slump them together and obscure their organic distinctions in one name; for if it be just to say—and I contend that it is—that these varieties of phthisis differ in their origin, in their course, in their complications, in their response to environments, in their duration, and in their issues, then surely it is not just but necessary to the progress of our art that they should be separately recognized and separately named."

These then are the views of an eminent English physician. While, of course, nothing is said that is really new, the fact that they have

been expressed by one so justly and generally esteemed as Sir Andrew Clark, is of great significance. Their general acceptance by old-school physicians will mark an era of advancement in therapeutics.

THE PRIZE ESSAY ON HOMŒOPATHY.

OUR old-school contemporaries all over the country have announced that Dr. George M. Gould, editor of the *Medical News*, offers a prize of one hundred dollars for the best essay showing "the ridiculous pretensions of homœopathy." It is proposed that the essay securing the prize shall be printed in large quantities, sold to the profession at cost of production, and used by them as a campaign document among the laity in order to destroy homœopathic patronage.

We do not apprehend that the prize essay will create much of a sensation. Too many essays of like nature have been published in times gone by, and all have fallen flat. Probably the most ambitious of these was that by Dr. S. O. L. Potter, of San Francisco. This was printed in large quantities, and sold to the profession at cost of press-work and paper, and yet had but a limited circulation. It proved the industry and pertinacity of its author and nothing more. It was not, moreover, always careful in its quotations. For example, much of the article was taken up with the effort to show that when any active treatment was required, homœopaths resorted to allopathic measures. In support of this was a case quoted from the *HAHNEMANNIAN MONTHLY*, in which the author finally resorted to drugs recommended by a writer in the *Medical and Surgical Reporter* for the vomiting of pregnancy. Dr. Potter represented the author as saying that these drugs controlled the vomiting at once, and yet, on referring to the original article, we found that the author said "these controlled the vomiting as long as their administration was continued." At the lapse of three days, however, they failed to relieve, and a miscarriage was therefore produced.

We expect that the Gould prize essay will contain but little aside from misrepresentation. Articles of that character show their nature at once. They deceive no one. It is announced that but one side of the question will be heard.

We do not think that the proposed essay will do our school any harm. On the contrary, we feel that whatever influence it does exert will be to our advantage. We hope it will be widely circulated, and yet we doubt it. Old-school physicians of large practices

will not have the time to bother with it, and therefore will not distribute it. Those having little or no practice will not have the money to buy. It looks, therefore, as though we will not get the advertising the "prize essay" should give us.

In order to encourage the essayist, a well-known homœopathic physician will gladly contribute twenty-five dollars in addition to the one hundred dollar prize, provided Dr. Gould will publish an answer to the prize (?) essay in the next number of the medical journal publishing the essay, or will bind the answer with the essay in pamphlet form. This offer is in good faith, and if he needs help in the money line to defray the increased cost of his pamphlets, this will also be supplied.

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES.

THE Association of American Medical Colleges held its third annual meeting in connection with the recent session of the American Medical Association at Detroit. From the journal published by the latter body we glean the information that the College Association is prospering, and that its membership is increasing rapidly, but it does not gain support from the South. In fact, several southern colleges, thoroughly in sympathy with advanced medical education, have withdrawn, as their compliance with the regulations of the society prevents them from competing with other colleges not in affiliation with it.

The remedy for this state of affairs is very plain. Unless all colleges unite in the Association, the standard of medical education cannot be raised. Something must be done to compel the outsiders to come in. The American Medical Association can apply the remedy, and it will do so if it is as anxious, as it claims to be, to improve the medical standard. Let it make ineligible to membership all physicians graduated from medical colleges not complying with a fixed standard. This will effectually debar all such from membership in national, state, and county societies. There are probably many who do not care to join these societies, but there are none, or at most very few, who care to be pronounced as unfitted to be associated with their professional brethren.

OWING to the unusually large number of sessions held simultaneously, a complete report of the sectional meetings of the A. I. H. was impossible. A full report of the general sessions will be found on page 112 of the NEWS AND ADVERTISER.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D.,

FRANK H. PRITCHARD, M.D., AND EDWARD M. GRAMM, M.D.

INTERLOBAR PLEURITIS.—Professor Potain recently had a woman who had just given birth to a child under his care. The labor was apparently normal and the patient was progressing well when suddenly the temperature ran up to an alarming height, and was accompanied by dyspnoea, weakness, and emaciation. Auscultation revealed but few traces of pleuritis. Pulmonary phthisis was thought of, as this affection is frequently observed in the puerperium. The apices were found normal; besides, the fever did not show the irregularity of the fever of tuberculosis. For several days no diagnosis was to be made. Another examination revealed a belt of dullness, with diminution of the vesicular murmur posteriorly on a level with the subspinal fossa left, extending nearly to the vertebral column posteriorly, and being prolonged anteriorly towards the axilla up to the margin of the sternum, forming a species of half belt, four or five centimetres in width. The dullness was deep and only to be made out by forcible percussion. There was no bronchial souffle here, and the vesicular murmur was only superficial. Evidently a collection of fluid in the interlobar space was in question, and the diagnosis was interlobar pleuritis. As in all pleuritides, it is very important to know the nature of the exudate, and two exploratory punctures were made, but without results. Still, the diagnosis was not changed. Interlobar pleuritis was known to Lænnec and Bayle, the former leaving an excellent description of the disease. The researches of Baron, Martinelli, and Perrier have completed the clinical picture. It is difficult to discover why the disease localizes itself thus. At the necropsy one finds an adhesion uniting the two margins of the interlobar sulcus, and on cutting into the lung one sees a quantity of fluid gush up from between the lobes. When the liquid is sero-purulent, the borders of the fissure are colored a yellow, from deposits from the exudate. When the disease reaches a typical development, the margins of the fissure are united by more or less thick false membranes, with a stratified character or a roughened surface. Exceptionally the liquid is serous; generally one has to do with a purulent or sero-purulent focus, the contents of which are exceedingly fetid from gangrene of the sac walls. In ordinary cases of pleuritis the exudate is found behind and below. In the majority of cases the exudate is purulent, in a few serous. When it is purulent it distends the cavity containing it, ulcerates the lung, and pours into the bronchi, in which case a spontaneous cure follows. Interlobar pleuritis is due to no special causes. It may follow any cause that produces a purulent pleuritis of the pleural cavity, eruptive fevers, especially scarlatina, erysipelas, or typhoid fever. In pleuritis it may develop insidiously. Generally the disease is easily recognized. For some days the patient complains of malaise, fever, slight chills, and sweats. When there is piercing pain, it is situated posteriorly, and may be very violent. It is located at the angle of the scapula. Cough and constipation. The fever easily rises to 39° C or 40° C. If, then, one percusses on a level with the median portions of the thorax, a belt of dullness will be found. Sometimes an intense bronchial souffle may be heard. At about the fifteenth day the pus breaks through the bronchi and is coughed up. If the quantity is great, one may fear death from suffocation. At other times the pus is easily expectorated,—like in phthisical patients with cavities in their lungs. The expectoration is rarely fetid, and rapid amelioration generally follows rupture of the focus. Convalescence takes place in a few weeks and the patient is cured. When the liquid undergoes alterations or is very large, a surgical operation is frequently necessary. Diagnosis of this disease is very difficult in many cases. The initial symptoms may be limited

ERRATA.—July number, page 523, line 23 from bottom, for ($\frac{1}{8}$ gramme) read ($\frac{1}{8}$ grain).

to a little fever and cough. A few days after physical examination reveals the characteristic signs. Often the vomicae are the first signs that lead one to the right diagnosis. Pulmonary gangrene is easily confused with interlobar pleuritis, with fetid expectoration. In gangrene of the lung there is a previous history of pneumonia, and the fetidity is more pronounced. It should not be forgotten that the two diseases may be combined in the same individual. When the disease is without complications, the pus is easily evacuated, and when the general condition of the patient is good a surgical interference is not necessary. Exploratory puncture is often of service to ascertain if there be pus present. Unfortunately, as in our case, one does not always succeed in striking the focus. This often occurs from the liquid assuming the form of a crescent with the convexity below, so that the needle passes over the fluid. In some cases repeated punctures will lead to a cure of a case undergoing suppuration. A patient coming under the writer's observation was punctured seven times, and in this manner cured. This is, however, exceptional, and in general the patient emaciates, grows feebler, and when the expectoration becomes abundant and fetid, one must operate. Prengreuer was the first to perform this operation, in 1886, and he was followed by Thiriar.—*Gazzetta Degli Ospitali*, No. 86, 1892.

THE ARTERIO-SCLEROTIC CONTRACTED KIDNEY.—Dr. Leven finds the connection between disease of the bloodvessels and the renal changes to be quite constant. Arterio-sclerosis need not be spread over the entire vascular system, for if this were the case, the relation between the two would have been observed before. The end-arteritic process is, in most cases, limited, and only the heart is always attacked. Leyden calls attention to the constant coincidence of disease of the coronary arteries. Involvement of the vessels of the pia mater is more constant and characteristic. Here the intensity of the process is greatest. The vessels of the base of the brain are similarly affected, and one finds here a number of opaque, white, endarteritic spots of the size of a grain of wheat. The pia is usually oedematous, the dura thickened and crossed by fibrous bands. The spleen is also implicated, all the signs of arterio-sclerosis presenting themselves to the eye under the microscope. The heart, in most cases, is only hypertrophied in the left ventricle, with beginning degeneration of the muscular elements. The kidney presents the characteristics of the red, granular, and atropic form of Bright's disease. Albuminuria, though present in the majority of the cases, is not always present. At all events, the quantity is but small. The quantity of urine is always diminished; indeed, it may sink to a very small quantity without dropsical symptoms setting in. Oedema and dropsy may be observed, as a matter of course, yet they are relatively infrequent. They may disappear for a long time completely. The specific gravity of the urine is only slightly heightened; uræmic states, vomiting, etc., sometimes make their appearance; retinitis is very rare. Leyden, in his series of cases, does not mention it. The age of the patient is another indication of the disease, as it is excluded in persons of advanced age. Although the differential signs are not very clear, a diagnosis is easily arrived at. The arterio-sclerotic contracted kidney is to be suspected in patients, mostly of the male sex, who have never presented signs of acute nephritis, yet who, in the course of time, begin to have slight albuminuria, fugitive oedema, decreased amount of urine of a light color, hypertrophy of the heart, and slight uræmic symptoms. Especial weight is to be placed on the presence of but little albumin in the urine. The enlargement of the spleen is also to be taken into account. The prognosis is somewhat more favorable than in the other varieties of nephritis, yet always and at best gloomy with regard to the final result. Prophylaxis is of great importance. Alcoholic drinks should be forbidden, and digitalis, in allopathic doses, should never be given.—*Deutsche Medizinische Wochenschrift*, No. 21, 1892.

CONDITIONS SIMULATING CHOLELITHIASIS AND GALL-STONE COLIC.—Professor Fuerbringer, of Berlin, was called in consultation during the summer to four cases where there was thought to be gall-stones present, and, in which cases, bodies had been passed resembling gall-stones. These proved to be peculiar bodies of the size of a poppy seed to that of a pea, of striking hardness, of the color of cork or reddish-brown, and either having taceetes or resembling a mulberry. Chemical analysis revealed the absence of cholesterine, biliary pigment and lime, while microscopic examination showed the only constituents to be stony cells from eating too many preserved pears. These patients, females, had at the same time suffered from nervous hepatic colic, or rather hepatic neuralgia. This led to their being

diagnosed as cholelithiasis. The writer has collected already six cases from his recent experience. He, in harmony with the investigations of Budd, Andral, Beau, Frerichs, Fauconneau-Dufresne, Durand Fardel, and others, outlines the characteristics of this affection, so little known to the majority of physicians :

1. The attack as much resembles that of true gall-stone colic as one egg does another, with the radiating pains; yet the pain is most intense at and in the region of the liver itself.

2. Nervous or hepatic colic is a symptom of nervous weakness of the nervous system—neurasthenia. It is met with, chiefly, in youthful, anæmic, neurasthenic, and hysteric patients, who are especially liable to present other visceral neuralgias, as plenodynia, cardiac pains, renal neuralgia, or oöphoralgia. Sometimes, the patellar reflex will be found to be greatly exaggerated in these cases.

3. The immediate cause of the attack is, in most cases, not to be discovered, and only, occasionally dietetic errors, over-exertion, anger, or menstruation.

4. There is, frequently, a certain periodicity in the appearance of the attacks—they may set in every night, every fourteen days, monthly, or even four times a year.

5. Icterus, and swelling of the liver, have always been found absent in all cases.

6. The liver is, in all cases, sensitive to pressure. Finally, as a differential diagnostic point, in spite of the affection persisting for years, there never appear any feverish, inflammatory, local affection of the liver, as is seen in cholelithiasis. Treatment at Karlsbad, where the majority of the patients are sent, does more harm than good. On the contrary, rational anti-neurasthenic treatment will lead to very appreciable improvement.

To the nervous colic of the liver may be added those cases which offer violent visceral neuralgias from adhesions between the liver and the neighboring organs. In these cases adhesions generally follow cholelithiasis.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

TEST TUBES FOR EXPLORING WOUND CAVITIES.—Fulton (Salisbury, Md.), recommends the use of the endoscope, in the shape of a glass test tube three to five-sixteenths of an inch in diameter, to explore bullet wounds of the brain. The former size can be safely introduced through the wound of a 22-calibre bullet, provided the track is straight or nearly so. A case is recorded in which good definition was obtained, with an ophthalmoscopic mirror, both at the sides and extremity. Although the bullet was not found and the patient died, the following advantages are claimed for the method :

1. The glass tube is ideally aseptic.
2. It is delicately responsive to the touch and easily directed by the sight.
3. Instruments can be inserted alongside of it, and their manipulation aided by the sight.—*University Medical Magazine*.

PULMONARY GANGRENE.—Perier (Paris) successfully operated a case of pulmonary gangrene that had several times relapsed, and presented alarming symptoms of septicæmia besides a glycosuria (three per cent.) There was abundant purulent expectoration, of a characteristic odor, and the lesion was located at the level of the second intercostal space. An incision was made anteriorly and the pectorals, intercostals, and pleura successively divided. The lung was held against the opening and incised, but found healthy. By pushing a pair of Sims's forceps into the lung tissue, the cavity was reached, the blades separated and withdrawn, giving a free exit to the pus. The cavity (with a capacity of about sixty cubic centimetres) was cleaned and drained with two tubes. Immediate improvement followed and healing was complete in seven weeks.—*Bulletin de L'Académie de Médecine*.

TREATMENT OF LEG ULCERS.—Morton (Philadelphia) has obtained good results by treating ulcers of the leg in the following manner:

1. The surrounding skin is thoroughly cleansed with soap, brush and water.

2. The ulcer is sprayed with peroxide of hydrogen (fifteen volume solution), and, when the effervescence ceases, irrigated or mopped clean.

3. The ulcer and one inch of the surrounding skin are covered with sterilized strips of "Lister protective," half an inch wide and overlapping each other one-eighth of an inch. These are covered with several layers of gauze wrung out of bichloride solution.

4. The bandage is not the ordinary one with reverses, but, on reaching the calf, it is carried up the limb as an ascending spiral to just below the knee, when a circular turn is made, and it is brought down as a descending spiral. This is repeated until the leg is covered. The parts are more evenly supported and the bandage is less apt to slip by using this method.

5. The dressings are changed daily until the parts become odorless, free from irritation, and aseptic, after which they are renewed every other day, or at still longer intervals.

When the discharges are excessive a pinch of iodoform or aristol is dusted over the surface, or the ulcer is painted with the pyoktani pencil.

To stimulate granulations which are slow or flabby, they are wiped with nitrate of silver solution (fifteen grains to the ounce), or the ulcer and its surroundings are scarified with a tenotomy knife.

Exuberant granulations are removed by the silver nitrate pencil or by scarification.

Among other methods of skin grafting to hasten cicatrization, epithelial cells from the skin, under the protective at the edges of the ulcer, may be scraped off and gently spread over the granulations.

When sloughs are present and retard healing by slow separation, they are dissected off or digested with pepsin. A wall of tough cerate is built around the ulcer and into this the following solution is poured :

R.	Pepsin pure,	.	.	.	.	.	.	.	.	.	.	gr. j.
	Water,	.	.	.	.	.	.	.	.	.	.	℥j.
	Hydrochloric acid,	.	.	.	.	.	.	.	.	.	.	℥j.

M.

This is renewed from time to time, and allowed to act for about an hour, when the slough is softened and loosened so that it can be easily removed; or better, a small quantity of papoid, or vegetable pepsin (which acts in a concentrated medium of any reaction-pepsin acts only in a dilute acid solution) is dusted in under the protective and allowed to act until the dressing is changed.

When the cellular tissue, lymphatics, or veins are affected, or the surrounding skin is eczematous or indurated, the protective is covered, in the place of the gauze, with lint spread with an ointment of ichthyol ammoniate (twenty per cent. in lanolin). The limb is wrapped in wax paper, held in place by the bandage—*New York Medical Journal*.

GASTRORRAPHY FOR DIMINISHING THE SIZE OF A DILATED STOMACH.—Weir (New York) successfully practised this operation for gastric atony and consequent dilatation, following a gastro-enterostomy for pyloric stenosis. The symptoms were gastric distress and vomiting, which recurred soon after the relief of the stenosis. The greater and lesser curvatures of the dilated organ were united in the following manner: The anterior wall of the stomach was depressed with a sound to the depth of about an inch, and, over this, the muscular and serous coats were united for a distance of six or eight inches. The sound was then withdrawn, another furrow made and the edges again united. With four such rows of sutures some four or five inches of the two curvatures were united, and the wall turned in to an extent equal to the breadth of the hand. The annoying symptoms disappeared at once and had not recurred at the end of three months.

Bircher (Aarau, Switzerland) has performed the same operation three times with good results. It should be thought of during operations for the relief of stenosis, and in frequently relapsing cases of chronic dilatation.—*New York Medical Journal*.

METHOD OF CONTROLLING HÆMORRHAGE DURING AMPUTATION AT THE HIP-JOINT.—Boone (Shanghai, China) proposes a simple means of hæmostasis for such operations, which he deems superior to the methods of Jordan Lloyd and Wyeth. In the former, a skilled assistant is necessary; in the latter, two steel pins (twelve inches long and one-quarter inch thick) are needed, and the soft parts are injured by the transfixion.

The elastic tourniquet can be secured as follows:

A pair of suspenders of non-elastic webbing are thrown over the shoulders of the patient; a handkerchief is tied around the sound thigh, under this two stout tapes (eighteen inches long) are passed, one in front and one behind the limb; these are fastened to the buttonholes of the suspenders, front and back. Similar tapes are laid along the abdomen and thigh of the side to be amputated, two anteriorly and two posteriorly, and about five inches apart. The elastic tubing is wound around the thigh as high as possible and fastened. The tapes are then looped through the two front buttonholes of the suspenders on the affected side, and through the buttonholes on both sides behind. By tightening the suspenders the tubing can be drawn up as far as possible, is firmly and safely held in place, and no assistant is needed to look after it.—*Medical News*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

METHOD OF PREPARING ANTISEPTIC LAMINARIA AND SPONGE TENTS.—Laminaria tents, destined for uterine dilatation are often found in commerce, under the form of round smooth little sticks, perforated after the suggestion of Greenhalz or solid, of progressive calibre, but of uniform length.

One can find but few, I believe, of but six and fewer yet of eight centimetres. They are generally provided at their base with a string to facilitate their removal, the utility of which is very doubtful. The principal advantage of these tents consists in the ease of their introduction, on account of the evenness of their surface, but on the other hand they present a double inconvenience.

1st. Being of equal length, they do not correspond to the size of every uterus; as a result, if very long they press against the posterior vaginal wall, and produce there, especially if the patient walks about, either a perforation, or an ulceration more or less deep. If too short, they become imbedded during their swelling especially in nullipara, above the origin of the os tincæ; and considerable difficulty may be experienced in removing them.

2d. In the second place, these tents, very smooth and perfectly cylindrical reveal all their faults when they dilate, that is to say knobs and rough places then occur which insert themselves into the internal orifice, and make their withdrawal very difficult and painful.

Sponge tents are found prepared in two ways: in the form of cones without roughness, and under the ancient form of sponge—wrapped with strong thread.

The cones are ordinarily very short, and by reason of their form and dimensions while easy to introduce, yet they dilate but little more than the cavity of the cervix.

To these as to the sponge *à la ficelle* one can find a double fault. One is never sure of their asepsis, nor of their being conscientiously prepared from a single sponge. It has happened, that one has left a fragment in the uterus, believing that he has removed the entire tent, and it is easy to realize the dangers of such an accident.

Finally, laminaria and sponge tents thus prepared are relatively high priced, and however secondary such a consideration may be, it is not to be neglected.

I have tried, for my personal use, to remedy in a practical and economical manner, these desirable points, and for some two years now have used satisfactorily, laminaria and sponge tents prepared in the following manner.

1st. Laminaria.—These which I used are the rough stems, bought by the pound, simply dried and unfinished. It is best to choose the smoothest and hardest, for some, of an earthy appearance, show themselves after swelling to be soft and friable, and liable to be crushed in the uterus from the pressure of the forceps.

They are divided then into pieces of different lengths of 6, 8 or 9 centimetres, taking into account also their expansion during swelling. After scrubbing and washing them to get rid of any foreign matter that may adhere to them, they are plunged into a cold solution of bi-chloride 1 to 1000, contained in a vessel sufficiently large to prevent them when swelling from pressing against one another. It is well to cover the vessel to prevent the entrance of germs from the atmosphere.

The tents do not attain their maximum swelling under 12 to 24 hours or even longer in a cold solution. The difference in time being due to different causes—their size, the temperature of the season, and of the room.

There is no disadvantage in letting them remain even longer; in fact, one can hasten the swelling by plunging them from the first in a tepid solution.

I then wash them in sterilized water and let them macerate anew, for a certain time, say 24 hours or less in a 1 to 1000 naphtha solution which I obtain by the addition of 20 c.c. to the litre of an alcoholic solution of naphthol, 1 to 20.

It is only necessary to take them out of the basin, rounding an extremity with a sharp blade and allowing them to dry. The drying should not occur in the open air lest they become again contaminated; they should be enveloped in gauze or antiseptic wool.

By this means, the time required is from 5 to 10 days according to the surrounding temperature and the thickness of the tents.

The result may be more rapidly reached by a moderately warm stove, or what is more readily within the reach of every one, in a cooking oven, on condition that they are protected in a proper vessel.

Whatever method is followed it is best to inspect them and not allow them to grow too dry, as this renders them hard, brittle and difficult to introduce. When they are sufficiently simple and malleable, so that they can be almost completely bent back, I plunge them in a 1 per cent. solution of naphthol in ether or a 5 per cent. of iodoform. These finish their contraction and preserve their suppleness, and they can be kept indefinitely in this way until wanted for use.

Thus prepared, the tents are simple and assuredly antiseptic. It is easy after measuring the uterus, to choose the suitable size—one can easily shorten them with a single cut.

Finally, I desire to call attention to a small point. These tents are of an unequal appearance and do not please the eye at first like those of the shops. However, they dilate in a perfectly cylindrical shape, entirely smooth and without any of the inequalities found in the others. This evenness of their surface perfectly assures the vent of the secretions and renders any central perforation unnecessary and makes their withdrawal easy.

The suppleness which they preserve renders their introduction easy, and if they ever become too dry, it is easy to soften them by immersing them for a few seconds in a warm sublimated solution.

Sponges.—I make use of two kinds; the small Indian sponge, making a single tent and those with a coarse base from which diverge long conical pieces more or less divided and voluminous; out of each of these cones, detached and trimmed up by the scissors, will result a long stalk, which will make a number of tents. Bound down by a string around them they are not much larger than laminariae of large or even of moderate size. Very resisting, they do not tear when pulled upon by the forceps and produce a very fair amount of dilatation.

More uneven than the prepared cones, they are not so easy to introduce and therefore are not so good to begin dilatation with, but after partial dilatation is effected they are placed without difficulty.

I bleach them with permanganate of potash and sulphite of soda, which also being an antiseptic agent, destroys any germs they may have accumulated.

After cutting and cleaning them of any calcareous matter, they are submitted to the same treatment as the laminaria, that is, immersed for a number of days in Van Swieten's liquor, washed in boiled water and plunged finally into the naphthol water, and then squeezed and compressed firmly by the thread of whipcord tied around them. The whipcord also should be immersed for several days in a sublimated solution before using and each spiral turn should be made closely and entirely in contact.

In this manner is obtained long aseptic stalks, sufficiently firm, which can be cut to the desired length and which can be inserted easily into the cervix partially dilated by laminaria and which themselves dilate perfectly cylindrically.—S. Burnet, *Annales de Gynecologie et d'Obstetrique*, 1892.

THE RELATION OF DERMOID CYSTS TO THE UTERUS—F. Ahlfeld.—He reports a case where the cyst lay exactly in the median line, in front of the uterus. Its position would change a little when the patient lay on her side, but returned always to its former position when the patient was on her back. Küster had repeatedly observed that this peculiar position of a cyst was characteristic of dermoid tumors.—*Centralblatt für Gynäkologie*, No. 12, 1892.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,

FRANK H. PRITCHARD, M.D., AND E. M. HOWARD, M.D.

TREATMENT OF ANGINA PECTORIS.—Dr. P. Jousset, of Paris, France, defines true angina pectoris as an arterio-sclerotic affection being always connected with chronic aortitis. In the majority of cases there is an obliteration of the coronary arteries by endarteritis, and when the arteries are found permeable the inflammation of the aorta has extended along the coronary arteries and caused a spasmodic contraction. The cases of fatal angina pectoris, with permeability of the coronary vessels, are explained by propagation of the inflammation from the arterial coverings to the nerves of the cardiac plexus. This is possible but an exception. False angina pectoris is a neuralgia of a hysteric or hypochondriac nature easily determined by an abuse of coffee or tobacco especially. [It may also be due to spermatorrhœa, sexual neurasthenia, as seen in the cases of Peyer, of Zurich, Switzerland, *Die angina pectoris nervosa s. spuria beim Manne*, *Wiener Medizinische Presse*, No. 25, 1892. See next number of this journal.—EDS.]

Treatment.—Treatment is divided into treatment of the disease and treatment of the attack.

Treatment of the Disease.—This consists in the treatment of the arterio-sclerosis at the bottom of the affection with a few modifications necessitated by the seat of the affection.

The iodide of sodium, the chloride of iron, the arseniate of antimony, spigelia and bryonia are the principal remedies.

Iodide of Sodium.—We simply refer to our article on arterio-sclerosis suggesting that the iodide of sodium should be continued for years. Professor Huchard has published several cases of cure from the use of this remedy.

Spigelia.—This is a very important drug in the treatment of angina pectoris. It corresponds to the anguish, substernal pain and its radiation in the arm and neck. Tendency to syncope, irregularity of the pulse, provocation of the attack by corporeal exertion are all confirmatory of the indication of spigelia. Give the first attenuation and the mother tincture, one to five drops a day.

Arseniate of Antimony.—This is one of the remedies of aortitis, and therefore of value in the treatment of angina pectoris, and although Hartman and Baehr have warmly recommended arsenic in the treatment of angina pectoris, yet the writer regards it inferior to the iodide of sodium and spigelia.

Chloride of Gold.—This drug is recommended by Dr. Bernard. Indeed, the pathogenesis of aurum muriaticum contains the pain in the region of the aorta, with irradiation into the axilla and a tendency to fainting. Administer from the sixth to the third trituration.

Bryonia.—This remedy has been found of service when the pain was exceptionally severe on exertion. Use from the sixth to the mother tincture.

Hygienic Treatment.—Drink milk, abstain from alcohol and even wine. Diminish the quantity of meat eaten as in arterio-sclerosis. Use no tea, coffee or tobacco as they easily provoke an attack. Avoid all bodily exertion even that of defecation, which may be facilitated by the employment of injections. Rapid walking or walking up an elevated plane, living at the seaside or in the mountains is to be forbidden.

Treatment of the Attack.—The nitrite of amyl, glonoine and morphine are the remedies to be depended upon in the treatment of the attack.

Nitrite of Amyl.—This drug has a very rapid action. It is found in pharmacies

put up in very convenient capsules. One of these is crushed in a handkerchief and inhaled.

Glonoine.—This drug acts in much the same manner as the nitrite of amyl, only that its action is less violent and more lasting. Use the 1-100 solution by aspiration or five to ten drops in a teaspoonful of water. It may be given subcutaneously by adding thirty drops of this solution to 10 grammes of distilled water. Each syringe-ful then contains three drops of the original 1-100 solution.

Morphine.—Hypodermic injections of morphine may be employed when the other remedies are insufficient and the pain is atrocious. Cases of sudden death appearing after subcutaneous injection of morphine are merely coincidents.

TARENTULA CUB. IN HÆMORRHAGIC SCARLATINA AND DIPHTHERIA.—A boy five years old had a malignant type of these diseases. On March 7th (seventeenth day) both ears began to discharge pus freely; a large abscess opened on left side of neck. On the same day obstinate passive hæmorrhages set in from nose, mouth, stomach, and bowels; petechiæ. Tarent. cub. was given (alone) when I left in the evening; the next morning he was better (I had expected to find him dead) and continued to improve steadily under it until April 6th. March 16th an abscess on right side of neck, opened on the 19th, cleaned daily with hydrogen peroxide and carbolic wash. April 6th, calc. sulph. was prescribed, and a week later the patient was given baryta carb. and discharged convalescent.—Dr. E. H. Spooner, in the *North American Journal of Homœopathy*, June, 1892.

SULPHUR IN CHRONIC DIARRHŒA.—An old soldier, suffering from chronic diarrhœa, "had taken everything." Every day he had six or seven passages; sometimes more, seldom less; yellow, watery, painless stools, requiring him to get out of bed early in the morning. I prescribed for an acute trouble, which in a week he reported "well;" then, for the diarrhœa, gave natr. sulph. 6, the next week he reported "no better;" he then received sulphur 30; the following week he reported "no more diarrhœa."—F. Percy Jenks, in the *North American Journal of Homœopathy*, June, 1892.

HYSTERO-EPILEPSY.—Dr. Windelband, of Berlin, in a paper read before the Homœopathic Society of Berlin on the results which he has obtained in hystero-epilepsy, chooses atropine, cuprum metallicum, stramonium, platina, and strychnine, respectively, and nux vomica, as the principal ones.

Atropine.—This drug was unknown to Hahnemann and our forefathers, yet belladonna presents a series of symptoms resembling hystero-epilepsy, respectively, the convulsions. Atropine has a more pronounced action upon the nervous system than belladonna. The writer regards atropine as the chief remedy in epilepsy.

Cuprum metallicum.—This drug is characterized by the following symptoms: Pressive pains in the head, eyes, præcordium, abdomen, chest and back. They disappear suddenly, return with a jerk or impulse, and are made much worse by contact or movement. It presents spasmodic movements of the eyelids, abdominal muscles, or those of the calves of the legs. While lying upon his belly, the patient suddenly throws his buttocks upwards. Cutting jerks of the head, twitching in arms and hands, spasmodic laughter. Convulsive attacks during sleep, twitching in the fingers, arms or hands, etc., epilepsy. Convulsions, with loss of consciousness, foaming at the mouth. Restless, tossing about, and continuous restlessness. Weird laughter, raving, and mental depression of every kind. The symptoms of the various extremities are: In the head, vertigo, sensation of pressure, the pressive pain is chiefly one-sided, with confusion of the head; the power to open the eyes comes later than the thought; dilated pupils, immovable pupils; the mouth is full of mucus; saliva collects in the mouth, salivation. In the stomach, there is slight eructations, violent nausea; cardialgia; spasmodic motions of the abdominal muscles; pressure in the præcordium; dull stitches in the cardiac region, pressive pain in the abdomen; constipation, inclination to stool. The sexual instinct is excited (keepers of dogs are in the habit of giving copper-filings to bitches to make them in the heat.) In the respiratory organs, there is long-lasting hoarseness; cough, lasting from one-half to one, to two hours. Pressure in the cartilage of the third rib, and drawing pain in that of the sixth rib. Rapid breathing, spasmodic attacks of asthma, the breath is short to suffocation. Sharp stitches immediately below the heart. Boring pain in the cardiac region, violent palpitation of the heart, etc.

Platina.—This remedy has not so pronounced convulsive phenomena in its pathogenesis, but it is a remedy, par excellence, in hysteria and hystero-epilepsy. The

symptoms are the most prominent. The patient is oppressed, melancholic, alternating with excessive joy; anxiety, feeling as if she were about to die, as though she were going insane. Vertigo; confusion of the head, with difficult or impossible speech, with partial suspension of consciousness. The sexual symptoms of platina are especially pronounced, and peculiar to hysteria. The menses are six to eight days too early, and accompanied with severe pain, and bearing down pains.

Stramonium.—This plant has a large number of symptoms of an excited nervous system, especially violent convulsions accompanied by outbursts of rage and loss of consciousness, etc. The menses are greatly increased.

Nux vomica.—This drug exhibits, together with greatly increased reflex excitability, convulsions of every variety; epileptic attack. It is a nerve remedy of the first rank. Its pathogenesis is well known. The writer states its action to be due chiefly to strychnine and not to brucine.—*Zeitschrift des Vereines Homöopathischer Aerzte*, No. Bd. xi., Hft. iii.

DR. MACFARLAN'S PROVINGS AND CLINICAL OBSERVATIONS WITH HIGH POTENCIES.—*Baptisia-tinc.*^{6m}.—Cured sore throat, enlarged tonsils: caused chilly and feverish sensations followed by sweat; somewhat later symptoms like intermittent fever; aches from his finger ends to his toes; very weak, sensation of fulness in stomach; eyes sensitive to light; checked disposition to sweat in hot weather. Passes water often, with scalding sensation; bulk of urine is clear, with film on it of variegated colors after standing; deposit of uric acid is seen after few hours in the bottom of the vessel; the whole larynx externally is very sore; speech and swallowing painful; feels as if she must expectorate; eyeballs sensitive; could not bear much light; soreness in right ear, and running down the neck; *neck feels so tired that she cannot hold herself easy in any position*.

Baryta-carb.^{cm}.—Sore throat; inflamed and enlarged tonsils; cured chronic inflammation of cervical glands mostly on the right side; had been very obstinate and resisted other treatment.

Belladonna^{101m}.—Given in cases of chronic conjunctivitis causes a sensation of burning in the eye, and feeling in the cheek bones as if scalded; has often helped the severe pain in cases of hip-joint disease. Relieved chronic enlargement of cervical glands of many years' duration. Woman, aged thirty, troubled since childhood; glands very large; had been treated off and on for years without benefit. Produced rash-like scarlet fever with severe tonsillitis, in several cases. Swollen lips and cheeks; pain over the eyes; thirst; sensation as of a swelling or lump in throat; vomiting, soreness in region of liver; bowels loose; sick and fainty very often; can scarcely keep anything in the stomach. Feeling of great pressure at middle of sternum. Produced symptoms of mania with disposition to violence in a case of advanced pulmonary consumption. With difficulty *keeps any food in the stomach*; too weak to hold his head up long; passes water freely; exceedingly cross; ill-tempered; drowsy; but cannot get sound sleep; bowels constipated very much; stools dark and hard; tongue coated white; uneasy; restless; rouses up and screams; starts and screams as if frightened; boy, aged six; verified in cases of other children; sick and fainty; vomits nearly everything; becomes at times as white as a sheet. Has cured vomiting often, particularly the vomiting of pregnancy. Relieved enuresis in two weeks occurring in a boy, aged thirteen, who had been troubled since infancy. Aching pain in all the teeth like dull toothache; mostly on left side; teeth feel sore to touch; great thirst; does not care much for food; wants to drink, which does not satisfy; burning sensation in pit of stomach; water nauseates him.

Benzoic-acid^{11m}.—Given and curative because of excess of phosphates in the urine. A severe, aching pain in occipital region, or cerebellum, was cured in a few hours, which had confined the young man to bed for three weeks.

Borax^{3m}.—Pain across his forehead for three days, with giddiness; then it passed to top of his head; giddy continually; soreness both sides of his neck; extending over the front of his chest; very severe in the middle of his sternum; cramps in the calves of leg.

Bromine^{cm}.—*Headache* all week; hammering sensation in the temples and top of the head; aching in both knee-joints; scanty urine; turbid, light in color; sensation of swelling in the throat; feels badly in a general way. Caused very sore throat; tonsils very red.

Bryonia-alb.^{103m}.—Severe pain in pit of stomach; general distress in epigastrium; bowels that were constipated more regular; nausea and general aching, with soreness in muscles.

Bufo^{45m}.—Severe sore throat; tonsils painful; swallowing at meals caused much suffering. Frequently verified.

Bursa-pastoris^{9m}.—Throat slightly sore; dryness of mouth; tonsillitis, tonsils swollen out even on a line with the angle of the jaw in one case; teeth sensitive when she shuts down on them; *gums spongy*; neuralgic feeling in teeth; slight *ranula* appeared. The girl had menstruated the week before, scantily, but it came on very profusely; she previously had amenorrhœa for some months. Slight sore throat; hoarse in the morning; peculiar pain between the end of sternum and umbilicus, like pricking of needles. Slight headache; pharynx sore, pain in stomach, felt generally as if he would be sick; nauseated; lips slightly sore; his finger joints hurt him greatly, as if rheumatic, and his urine burned in passing; pain in his left shoulder, so great that he thought his neck and shoulder would break. An abscess appeared on his finger on the tenth day; he then stopped the medicine for eighteen days; on resuming it in water, the upper portion of his throat became very sore, and the gums of upper and lower jaw on the inside felt as if full of blisters; crampish pain in stomach; toes hurt him; of course he did not know he was proving, and was made very sick. Swelling of the throat and face on left side, mostly; *violent fever*; throat painful; oppressed breathing during the fever; slight deafness and pain in the left ear; free discharge of blood and mucus from the left nostril; general bruised feeling.

Calendula-off.^{45m}.—Urine greatly diminished in quantity; left internal ear ached severely; piercing headache; eyes pained him because of the headache.

Chelidonium-majus^{5c}.—On sixth day, vomited his breakfast, then took a chill, which confined him to bed for a day. After that took no more medicine.

Croton-tiglium^{45m}.—Vomiting; very sore throat, felt mostly in the effort of swallowing; constant nausea and burning sensation in stomach.

Cichorium-intybus^{5c}.—Cured promptly two cases of hoarseness and pharyngitis; coughed a good deal night and morning.

Calendula^{45m}.—Face puffy and swollen particularly under the eyes. Several provers.—Urine greatly diminished; left ear ached internally very much; discharge from ear; splitting headache; eyes pained him because of headache. Feels as if he would fall from a height when dropping asleep; urine diminished greatly in all the provers, male and female; less than half the usual quantity was passed.

Cancer-fluv.^{5c}.—It pains him to turn his eyes; giddy, nervous crawls all over his body. One prover, given every hour for a week.

Capsicum-anuum^{1m}.—Produced a most severe attack of watery diarrhœa with cramps; neuralgic headache all over his head; coming on every little while: lasting but a short time; has to shut his eyes, aggravated by light.

Carb-sulph.^{45m}.—Pain seizes her, and comes so quickly as to cause a sudden jerk; pain begins at left elbow and runs down the left side to the foot. One prover. Only permanent symptom developed after taking medicine a week.

Caulophyllum-thal.^{5m}.—Produces hoarseness and loss of voice; caused pain and soreness in the ovarian region, mostly on left side; bearing-down sensation; frequently cures leucorrhœa, pain across sacrum, uterine and ovarian distress. In two cases of barrenness existing for years, when the medicine had been given for a long time, both conceived and bore children. I have found it a very reliable remedy in ovarian pain and soreness.

Chamomilla^{94m} (*Anthemis*).—One prover.—Child cries day and night; nothing pacifies it; disturbs everybody in the neighborhood; neighbors on both sides come in to see "what is up;" cries all night; had given it medicine every half hour during the day for two days; frequently cured this symptom of crying in children with chamomilla; child cries a great deal; cross and peevish without having any other ailment; no fever; fretfulness produced in a number of children.

Chelon-glab. (*F.*)^{45m}.—Flesh was so sore it seemed as if the skin was off her elbow; other joints affected in a less degree. One prover.

Calc-carb.^{97m}.—Frequently cured cases of marasmus in very young children with this remedy; they appear old, wasted, thin, especially those who had bronchitis without diarrhœa and without vomiting, when sulph., lyc., laurocerasus, etc., did no good.

Carbolic-acid^{45m}.—Promptly cured dry, scaly eczema of face, upper and lower extremities, of ten years' standing, which had resisted previous treatment of both schools.

Cadmium-sulph.^{5c}.—Too frequent seminal emissions often checked by it. Not pushed as a proving.

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CLINICAL METHODS AND RESULTS.

BY JAMES G. GILCHRIST, A.M., M.D., IOWA CITY, IOWA.

THE June number of the HAHNEMANNIAN contains an exceedingly interesting contribution from Dr. Vischer, of Philadelphia, giving the results of six months' work in the surgical clinic in the Hahnemann College of that city. The methods there employed are in tolerably strict accord with the so-called aseptic teaching, and give results that are pretty much the same as those in any hospital or clinic of any school of therapeutics. It occurred to the writer, after reading the above paper, that some profit might accrue to all interested in surgery if other clinical teachers would report their methods, as possibly too much is claimed for certain procedures as compared with others.

In the Homœopathic Medical Department of the State University of Iowa, the surgical clinic is well supplied. Material coming from a very broad territory, it is not possible to secure as large a clientage, possibly, as in a city like Philadelphia, but the manner in which this material is used, perhaps, gives the student about as much practical experience with surgical work as can be desired.

Of course, as in all schools, the character of the work varies greatly from year to year. One year it seemed to be abdominal surgery; another year, tumors; another, bone surgery, and the like. But, following the plan of Dr. Vischer, I will report the results of the clinical work of last year. The whole number of surgical cases

brought before the class was fifty-five, not including some minor cases.

- 1 tumor, prepuce, cyst; excised.
- 1 tumor, orbit, sarcoma; enucleation.
- 1 tumor, abdomen, lipoma; excision.
- 2 tumors, cheek, cysts; intra-oral excision.
- 1 tumor, parotid, cystic; excision.
- 1 tumor, breast, fibro-cystic; amputation.
- 1 tumor, mediastinum, sarcoma; *carb. ac.*
- 1 tumor, uterus, intra-mural fibroma; enucleation.
- 1 tumor, uterus, intra-mural fibroma; iodide of lime.
- 1 tumor, chest, molluscum fibrosa; excision.
- 1 tumor, hip, enchondroma; hecla lava.
- 1 tumor, ovary, cystoma; ovariectomy.
- 2 tumors, uterus, sub-peritoneal fibroma; laparotomy.
- 1 tumor, phantom; laparotomy.
- 3 tumors of scrotum, fibro-sarcoma; castration.
- 1 tumor of spleen, sarcoma, died; no treatment.
- 1 phimosis; circumcision.
- 1 phimosis; splitting prepuce.
- 1 hydrocele of cord; tapping.
- 4 hydroceles of tunica vaginalis: radical operation.
- 1 varicocele; excision of veins.
- 1 hæmatocele, long incision.
- 1 hare-lip; cheiloplasty.
- 1 caries of knee of tibia; amputation of thigh.
- 1 caries of femur; pepsin injections.
- 1 caries of ankle; remedies.
- 1 caries of sacrum; pepsin injection.
- 1 caries of spine; plaster-jacket, etc.
- 2 necrosis of tibia; sequestrectomy.
- 1 necrosis of femur; sequestrectomy.
- 1 double scoliosis; apparatus and gymnastics.
- 1 dislocation of hip (sciatic), ancient; reduction; plaster dressing.
- 1 synovitis, chronic, ankle; remedies.
- 1 halux valgus; apparatus.
- 1 talipes equino-varus; apparatus.
- 1 ganglion, compound, of ankle; subcutaneous section; *sil.*
- 1 ganglion, simple, of wrist; subcutaneous section; *sil.*
- 1 dactylitis syphilitica; remedies.
- 1 epithelioma of face; Mitchell's treatment.
- 1 epithelioma of lip; excision.
- 1 lupus exedens; *arsen.*
- 1 inguinal hernia, double; radical operation.
- 3 inguinal hernias, single; radical operation.
- 2 hæmorrhoids, internal; excision of mucous membrane.

The death from sarcoma of spleen occurred the day after admission, before any treatment had been instituted. This is the only death, by the way, in three years.

Now as to methods: The operating theatre is the same room used for lectures and classes, and not specially designed for the purpose; unpainted; wooden floor. No attempt is made to sterilize the atmosphere, partly because it is impossible to do so in any amphitheatre or lecture-room, and partly because the condition of the body is believed to have more to do with the occurrence of morbid action than the presence of micro-organisms. Patients are bathed with water only; no germicides are used at any time or in any way, and none of the popular methods to secure asepsis are practiced. Instruments are not boiled or "disinfected," further than careful washing after use. Silk is used for ligatures and sutures, as a rule; occasionally, animal ligatures of various kinds or silver wire. Sponges are also used, both during operations and for dressings, but are destroyed when soiled. Each patient has his own sponges in subsequent dressings.

The clinical assistant is appointed from the graduating class each year, on competitive examination, serving as such one year. For his services he receives board, lodging and laundry, and a small stipend, in addition to facilities for post-graduate work in any department of the University. He details, in regular order, three senior students, as sub-assistants, in such manner that one goes out each week. By this plan, each student has three weeks' service, which includes daily visits to the wards for dressings and service at clinics in rotation. Thus, one week, charge of sponges; second week, instruments; third week, anæsthetic, with the clinical assistant. Patients are always anæsthetized in a room adjoining the operating-room, and carried back there before restoration to consciousness.

The anæsthetic used is the A. C. E. mixture in the majority of cases. Ether, being dangerous from remote effects, is never used where there are renal, pulmonary, or bronchial complications. Chloroform, on account of its immediately dangerous qualities, is rarely used. Pasteboard inhalers (a home-made cone, filled with absorbent cotton) is used for the A. C. E. mixture.

After every operation the wound is covered with a compress of absorbent cotton, wet with hypericum (watery extract), a dry compress outside of this, and a bandage over all. This dressing is not removed for several days unless soiled. *Hypericum*, ten drops in an ounce of water, is given in teaspoonful doses once in fifteen or twenty minutes for four or five hours; then once an hour for twenty-four hours, when it is discontinued. The temperature is taken frequently, according to the urgency of the case, and, if it rises quickly, *aconite*

6 or 30 is at hand, and doses given once in fifteen or twenty minutes. If the temperature does not fall within an hour, which in nearly every case it does, the physician is called. In abdominal cases, *arnica* or *arsenicum* is oftener the second remedy; in other cases, *rhus*. Any indication of erysipelas, which is not uncommon in scrotal operations, is met by *belladonna* promptly, and as promptly do they pass away.

After the first dressing, the dressings are dry. Suppuration is rarely encountered; mostly about suture tracks. There have not been three cases in a year in which there was enough pus to call for comment. In nearly every case there was entire absence of pain, due to the *hypericum*, and primary union, due to the remedies given on indications. My belief has always been that the best germicide is found in the best vulnerary, and the best vulnerary is pure homœopathic treatment. The tissues being in good condition, micro-organisms are innocuous. To keep them in that condition, let them alone, and keep the body, of which they are a part, well. It might be said, in passing, that my private surgical practice, averaging three cases a week (big and little) the year, is conducted on the same lines and yields the same results.

One word as to the case of phantom tumor. Why open the abdomen? The patient had a bad heart, and ether was used for anæsthesia. There was the usual excitement and struggling, and when anæsthesia was complete and the clothing turned down, the tumor was gone. Fearing there might have been a rupture of a cyst, the abdomen was opened, but everything was normal.

AN EVERYDAY CASE, WITH SOME HOMELY DEDUCTIONS THEREFROM.

BY E. H. LINNELL, M.D., NORWICH, CONN.

(Read before the Connecticut Homœopathic Medical Society.)

On the 6th of July, 1891, Mrs. B—— consulted me, saying she had for a year been under the care of one of our leading old-school physicians who had treated her for rheumatism without benefit. She was a middle-aged lady, with dark hair and eyes, and of healthy appearance. She complained of constant headache, confined mostly to the temples, and also of pains along the course of the right ulnar nerve, with numbness of the arm and hand. Digestion, men-

struction, etc., were normal. I gave her causticum 30x. She returned on July 14th, and reported that her head was no better, but that the pain and numbness of the arm and hand were somewhat relieved. I now noticed that the joints of the fingers were enlarged and tender, and learned that they were the seat of a constant dull pain. She also complained of soreness of the eye-balls to touch and on motion, and the headache was also aggravated by motion. I prescribed caulophyllum 6x, and owing to the seeming absence of any adequate cause for the persistent headache, I made an examination of the refraction, thinking it might be occasioned by unconscious eye-strain, as is so frequently the case. The examination demonstrated a normal visual acuity, but a hypermetropia of $\frac{1}{4}$ in each eye. That is, she saw clearly at a distance, but with an effort of accommodation represented by a convex lens of 48 inches focal distance. With the ophthalmoscope, I also diagnosed a hypermetropic astigmatism. The phorometer showed an exophoria of $1\frac{1}{2}^{\circ}$ at a distance of 10 feet, and of $6\frac{1}{2}^{\circ}$ at the reading distance. A word of explanation in regard to these last expressions may perhaps be not inappropriate, as this is not an assembly of specialists.

The phorometer is an instrument designed by Dr. George T. Stevens, of New York, to demonstrate the muscular relations of the eyes. By means of prisms, diplopia is produced, and these, if there is a loss of equilibrium of the extrinsic eye-muscles, one or both of them deviate in the direction of the stronger muscle. The visual lines should be parallel when the eyes are at rest and directed to a distant object. In my patient's case, however, there was exophoria; that is, a deviation outwards of the visual lines, greater at the reading distance than when looking across the room. Here, then, we found at once three sources of eye-strain. Hypermetropia, necessitating an effort of accommodation even at a distance, and a correspondingly greater effort for the near point; secondly, a hypermetropic astigmatism, rendering the retinal impressions of all objects somewhat distorted, and lastly, and perhaps more conducive to fatigue than either of the others, a loss of muscular equilibrium. I gave her experimentally + 40 spherical lenses for near work. At her next visit, on the 4th of August, the soreness of the eye-balls continued, and the pain extended from behind the eyes to the vertex. The rheumatism of the hands and arms was rather better. The glasses, as I anticipated, proved unsatisfactory, and I therefore paralyzed the accommodation by the use of atropin in order to make a more thorough examination of the refraction, and especially to de-

termine the degree and meridian of the astigmatism, and with the following result.

The vision was now only $\frac{10}{70}$ without glasses, but it was made perfect in each eye by No. 36 convex spherical, combined with a No. 60 convex cylindrical lens (to correct the astigmatism), set at an angle of 90° . With these glasses the phorometer showed muscular equilibrium at a distance. *Cimicifuga* 30x was prescribed, and also sphero-cylindrical lenses to correct the errors of refraction. After wearing them for two weeks she returned with the report that they were very satisfactory, and she wore them constantly, and felt that she "could not do without them." She had much less headache but it "was not quite right." The phorometer now still showed muscular equilibrium at a distance, but there was an exophoria of 10° in accommodation. The relative strength of the external and internal recti was now tested, and it was found that while the externi were of average strength, the interni could overcome prisms of only 10° with their bases toward the temples, or about one-third of the strength necessary for continued use of the eyes with comfort at a near point. She was now given a pair of spectacles with prisms of 8° , with bases out, to wear for half an hour daily, to exercise the internal recti. The effect of such spectacles is to produce double vision which can be overcome by turning the eyes strongly inward, and it was hoped, by this effort the muscles would be gradually strengthened.

At the next visit, September 23d, the exophoria was 2° at a distance, but only 4° in accommodation instead of 10° before wearing the prisms. Their use was continued, and in addition, the Faradic current was applied occasionally to each internus until the 12th of December, when muscular equilibrium for all distances was established, each internal rectus now overcoming a prism of 30° , and the headache was a thing of the past.

The rheumatic symptoms, however, had not improved during this time in spite of the use of appropriate remedies. On the contrary the knees and ankles had become stiff and painful as well as the upper limbs. I therefore sought to find a reason for the lack of response I felt I ought to have obtained from my remedies, and with this end in view I made an analysis of the urine. I found the quantity scanty, and the specific gravity high, and under the microscope numerous crystals of uric acid were observed.

The diagnosis of lithæmia was now established, and the retention of uric acid in the system explained the persistence of the rheumatic

symptoms. I now prescribed, in addition to the indicated homœopathic remedies, one drachm of citrate of lithia in a glass of water each morning before breakfast, and regulated the diet, and soon had the satisfaction of discharging my patient cured.

Several useful lessons might be drawn from this case. One of the first and most important of them is the importance of an accurate diagnosis. I am not one of those who regard a diagnosis as unimportant for successful homœopathic treatment. I might have gone on prescribing symptomatically for an indefinite period without correcting the error of refraction and restoring the muscular equilibrium; and I doubt not the headache would have gone on too. The condition of lithæmia might have been corrected by homœopathic remedies unaided, but the knowledge of its existence was a very decided help to me in treating the case; and the physiological action of the lithia as a solvent of uric acid, so far from counteracting the indicated remedy, increased its efficiency by removing the poison which was circulating in the blood and acting as an antidote thereto. Then it was possible for the remedy to remove the primary cause of the disease. Hence, lesson number two might be the desirability of cultivating a spirit of liberality and a readiness to employ, with caution and under proper restrictions, other measures in the treatment of obscure cases in addition to the homœopathically indicated drug. Lesson number three is the influence of eye-strain, from either of the sources mentioned, in causing headache and other nervous manifestations. It would doubtless surprise those who have never given special attention to this matter to know the severity as well as the variety of reflexes which arise from this cause. Many an obstinate case has yielded in my hands to treatment directed to the eyes similar to that outlined in this paper, and that, often when the patients were unaware of the existence of any trouble with the eyes. Therefore, in obstinate cases of a nervous character it may be of advantage to send your patient to a competent oculist. Just here I wish to remark that I find the use of prisms to exercise the weak muscles, or sometimes when the limit of development has been reached, so set as to relieve the strain of the still existing loss of equilibrium, will, in a very large majority of cases, succeed where many oculists make tenotomy. The latter procedure weakens the opponent muscle without strengthening the one primarily deficient, thus leaving two weak muscles instead of one.

Another point I would like to emphasize is the importance of a thorough chemical and microscopical examination of the urine, not

only in suspected renal disease, but as affording valuable aid to diagnosis in many obscure constitutional affections.

The last lesson I would draw from this narrative is the importance to the specialist of an extended experience in general practice. Without it he is one-sided and narrow, and his influence is correspondingly limited.

A SHORT SKETCH OF THE LIFE-WORK OF SAMUEL HAHNEMANN.

BY AUGUSTUS KORNDÖRFER, M.D., PHILADELPHIA.

(Read before the Germantown Club, Friday Evening April, 22, 1892).

It is meet for us this evening, to render honor to the memory of one who above all others in medicine, well deserves our praise. Therefore, and, in accordance with the request of our host, I have prepared this short sketch of the life-work of the illustrious founder of our school.

On the tenth of April 1755 at Meissen, Saxony, Hahnemann entered upon sentient life. How insignificant did this event appear to all save the loving parents of this human embodiment of untold possibilities; yet, in this tiny body was encased the soul of one of earth's greatest benefactors. One who was to become a noble, self-sacrificing follower in the footsteps of the Great Physician. A mighty intellect raised up in the providence of God for the purpose of overthrowing old errors, and destroying the idols of superstition and mysticism which so long had reigned in medicine; setting up in their stead the truth as expressed in the law of similars. To him belongs the honor of developing a system that at once established logical and scientific order in medicine; thus rendering possible the intelligent application of drugs to the cure of disease.

Hahnemann, like many of our greatest thinkers, was poor in this world's goods. His seriously limited means menaced his work for many years. During his early life his father, a painter on porcelain, was too poor to furnish the necessary tuition fees for a lengthened course of study; but the earnestness and intellectual ability of the son more than compensated for the limited means of the father. His teachers, recognizing his rare worth and tireless energy, voluntarily offered their services free of charge, in order that he might follow the bent of his inclination. Thus he was enabled to lay broad the foundations for his future observations and researches,

upon which his grand discoveries in homœopathy were in after years to be based. His logical and scientific exposition of medicine, bequeathed to the world nearly a century ago, has progressively increased in value and usefulness, until now, there is no civilized country in the world but has share in its blessings.

Adversity raised its barriers against him, but his spirit bid defiance to poverty and trial. Ceaseless, tireless effort is the key to all apartments in the temple of knowledge: this he possessed, this he employed.

Ambitious for knowledge, he was untiring in work, and in consequence was soon called into fields of practical duty, in which were trained those wonderful powers of observation and judgment, for which he became so noted in the years soon to come.

Quarin, physician to the Emperor of Austria, sought him out, cared for and instructed him in the art of medicine. Hahnemann says, "He singled me out, loved and taught me as if I were his sole pupil in Vienna, and even more than that, and all without expecting any remuneration from me." Quarin, was indeed a valued friend and influential patron. Under his teachings Hahnemann gained such experience and reputation that the governor of Transylvania, engaged him as resident physician, and authorized him to assume charge of his library. While thus engaged, Hahnemann, who was an accomplished philologist, reading even the Chaldaic, found opportunity to continue his studies in the various languages of which he felt need in pursuing his researches in medicine.

Two years later we find him at Erlangen, whither he resorted for his degree in medicine. Brilliantly sustaining his thesis, he received his doctorate, August 10, 1779; after which he returned to Transylvania.

In 1781, we find him occupying the post of parish physician, at Gommern. Here, on December 1, 1783, he married his first wife, Henrietta Kuchler. The year following he left Gommern, and removed to Dresden, where a wider field for study and observation was at his command. Here he soon became intimately associated with town-physician Wagner, and, owing to the ill-health of that official, Hahnemann was placed in charge of the town hospitals for one year. As this position required the consent of the magistrates, his election affords unmistakable evidence of the high estimation placed upon his skill as a physician, and the confidence which was accorded his practical ability. This fact alone is sufficient refutation of the oft' repeated calumny, that "he never saw practice," and

that consequently "his whole system was based upon theoretical surmises unsupported by actual knowledge of or experience in disease."

At Dresden, Hahnemann made good use of the libraries, as well as of the hospitals; but again his thirst for knowledge led him to seek still wider fields for study; consequently in 1789, he settled in Leipzig, in order, as he expressed it, that he "might be nearer the centres of learning." With increasing zeal, and with unfolding ideas Hahnemann pursued his studies and practice at Leipzig until 1792, when he received a call from the reigning Duke of Saxe Gotha, to assume charge of the Insane Asylum at Georgenthal.

Here Hahnemann attracted much attention through the radical change in treatment which he inaugurated; abandoning all corporeal punishment and substituting therefore a treatment which I can best express in his own words: "I never allow any insane person to be punished by blows or other painful corporeal inflictions, since there can be no punishment where there is no sense of responsibility, and since such patients only deserve our pity and cannot be improved, but must be rendered worse by such rough treatment." "The physician of such unfortunate creatures ought to behave so as to inspire them with respect and at the same time with confidence; he should never feel offended at what they do, for an irrational person can give no offence. The exhibition of their unreasonable anger should only excite his sympathy and stimulate his philanthropy to relieve their sad condition."

Thus in 1792, Hahnemann discarded the use of all mere physical force and employed the principle of moral restraint, practically, in the treatment of the insane. This occurred contemporaneously with the work of Pinel, who about the same time was striking the manacles from the unfortunates, incarcerated at the Bicêtre.

In 1795 he located at Königsutter, where he remained until 1799, by which time his successes had aroused the jealousy of the physicians of that town, who incited the apothecaries to bring action against him for interfering with their privileges by dispensing his own medicines. This action resulted in the enactment of a law restraining physicians from such practice. Hahnemann was therefore compelled to abandon his practice at Königsutter.

Between this time (1799) and 1810, when for the second time he made his residence in Leipzig, Hahnemann changed his place of abode quite frequently, owing to the persistent and unjust opposition of the apothecaries, who, through legislative or magisterial enactments, debarred him from dispensing, which necessarily precluded practice.

During these years he gave to the world some of his most searching arguments against allopathy. In 1796 he gave to the profession his "Essay on a New Principle for Ascertaining the Curative Powers of Drugs." In this essay we find the first distinct enunciation of the law of cure, and of his method of employing the symptoms obtained from provings on the healthy, as the basis under the law of similars, upon which the selection of remedies for the cure of disease might with certainty be effected. In referring to the various possible methods of treatment, Hahnemann classes as the first and most praiseworthy "the removal of the fundamental cause of disease," saying, "All the imaginings and aspirations of the best physicians of all ages were directed to this object, the most worthy of the dignity of our art." Commenting upon this method he asserts that "the cause as regards most diseases will remain concealed from human weakness." Again, "this object is above all criticism, though the means employed were not always the fittest for attaining it." Keeping in view such expressions, have we not reason to believe that, were he with us to-day, he would heartily co-operate in all intelligent research tending toward the elucidation of facts pertaining to the tissue changes in disease? After referring to the application of drugs under the principle of *contraria*, which he proves by many examples and by cogent reasoning to be a fallacy, he says, "I am not alone in warning against this fatal practice. The better, more discerning and conscientious physicians have from time to time sought for remedies, for chronic diseases, and for acute diseases tending toward the chronic, which should not cloak the symptoms, but which should remove the disease radically, in one word for specifics: the most desirable, most praiseworthy undertaking that can be imagined." Proceeding to demonstrate the necessity of learning the range of action of the individual drug, he recommends the proving of drugs in the following words: "Nothing then remains but to test the medicines we wish to investigate on the human body itself." He gives in brief the following two axioms: "Every powerful medicinal substance produces in the human body a kind of peculiar disease; the more powerful the medicine the more peculiar, marked and violent the disease." And secondly: "We should employ in the disease we wish to cure that medicine which is able to produce another very similar artificial disease, *similia similibus*."

The year following Hahnemann published an article in Hufeland's *Journal* entitled "Are the Obstacles to Certainty and Simplicity in

Practical Medicine Insurmountable?" In this essay he strongly urges the use of the single remedy, and supports his position with the most cogent reasoning. In 1801 he published an essay entitled "Observations on the Three Current Methods of Treatment," and soon after, one on the "Cure and Prevention of Scarlet Fever;" and another "On the Power of Small Doses of Medicine in General, and of Belladonna in Particular." All these papers bear marked evidence of the progressive steps by which he reached the developed system elaborated but few years later.

In 1805 he published his first volume of *Materia Medica*, the *Fragmenta de Viribus Medicamentorum Positivis Sive in Sano Corpore humano Observatis*. This was his first publication embracing the known effects of drugs upon the human body.

In 1806 we have the "Medicine of Experience," an essay embracing many thoughts which were afterwards more fully elaborated in the *Organon*, the first edition of which appeared in 1810, the last (fifth) in 1833.

In 1811 the first volume of the *Materia Medica Pura* came from the press; the sixth volume was completed in 1821; the third edition, much enlarged, was issued in 1830.

In 1813 we have from his pen the "Spirit of the New Medical Doctrine," an admirably written article, which should be studied by every student of homœopathy.

In 1828 he gave us that masterpiece of comprehensive thought and logical reasoning "The Chronic Diseases." The volumes of *Materia Medica* connected therewith were issued in 1828, 1829 and 1830, respectively. The second edition 1835 to 1839.

In 1831 he published "An Appeal to Thinking Philanthropists on the Mode of Infection of the Asiatic Cholera." This work is one of more than passing interest to us as homœopaths, in this day of bacterial study. Let it be here remembered that this was published about one year before the last edition of the *Organon* went to press—nearly sixty years ago. Speaking of the spread of the disease through careless physicians and nurses, he says: "They take away with them in their clothes, on their skin, on their hair, and probably in their breath, the invisible (probably animated) and perpetually reproductive contagious matter surrounding the cholera patient, and this contagious matter they unconsciously and unsuspectingly carry along with them throughout the town." Words of such import might well be attributed to a believer in the germ theory of to-day. Yet we still find within and without our school those who igno-

rantly attribute to Hahnemann a belief in the spiritual essence of disease.

While thus pursuing his distinctive life-work, Hahnemann continued an indefatigable worker in the collateral branches of medicine. He bestowed much thought and experimental research upon chemistry. His improvements in chemical technique were by no means insignificant, and several of his essays bear evidence of great chemical knowledge.

Hygiene and sanitation, both public and private, were treated by him upon such advanced principles that his views might do credit to a sanitarian of to-day.

During all these years we find this tireless worker, this astute thinker, this logical and cogent reasoner, this great discoverer, and, above all, this grandly conscientious physician, struggling against an opposition such as would have appalled a less noble spirit; contending against poverty which would have broken a less humble, trusting soul; reaping an ingratitude which would have chilled a less benevolent heart: still imbued with burning desire to follow in the footsteps of the Great Physician. Striving for more than a third of a century against the most virulent opposition, for the sole purpose of unfolding to the use of mankind a knowledge of that beneficent system of medicine in honor of which we are this evening assembled.

Look at him as you will, he is a man such as angels must delight to praise. Calm, though capable of strong emotion; emotional, yet schooled to the profoundest control; zealous, but dominated by a spirit of love which led him to works of humanity; learned, though employing his knowledge for the benefit of his fellow-man; with all these talents—yea, and more—yet holding them as a faithful steward ready to give account to the Master.

A strong argumentarian, he never sought by sophistry to maintain a faulty position. His power for satire, though keenly developed, was used with such judgment and care that it never transgressed its most proper limits, viz., exposure of the defective and blameworthy methods employed by the dominant school.

Though his adversaries—the adversaries of the truth—made him and his, to feel the sting of poverty for years, for this he never uttered words of chiding. His deepest regret in his poverty was the suffering entailed upon his loved ones. His courageous heart ne'er failed him in his darkest hours of trial. His reverence for the divine will and way made him a willing, faithful servant, striving to

perform the work of the Master. Once convinced of the right, nought could swerve him therefrom. *Truth* to him was sacred, the glory he gave to *God*.

Hahnemann indeed suffered the pinchings of poverty for many years, but, after his arrival in Leipzig, in 1810, his practice speedily increased both in numbers and emoluments, and he enjoyed the prospect of a tangible reward for his labors. This hope, however, was soon dispelled by the action of the apothecaries, who here again secured the enactment of laws which forbade the dispensing of his own medicines. This forced him to abandon the lucrative practice so recently acquired.

On invitation of the Duke of Anhalt Coethen, Hahnemann retired to the capital of that little principality in 1821; many of his patients followed him thither; here he continued in practice until after his second marriage, which occurred in 1835.

We may glean some idea of the extent of his practice during these fourteen years of quiet from the fact that, before going to Paris, he divided his accumulated means, about \$50,000, among his family. This fact affords another proof of the falsity of the assertion that Hahnemann wrought upon theory alone, unguided and unchecked by the corrective results of practice.

And now, gentlemen, I will close with the thought, cheering to the heart of every disciple of Hahnemann—the inspiring thought—that the day is fast approaching when our system—the system of Hahnemann—will be carefully weighed in the balance with other systems of medicine, by scientists trained to the dispassionate study of nature in her response to *law*. Dare we, then, doubt the recognition of the law of similars as the divinely appointed law of cure.

The day must speedily come when that once despised searcher for truth shall be crowned by the learned of all lands as a benefactor whom the world, long ages to come, will call blessed. Thrice blessed he who, faithful to his Lord, having received the truth, strives, despite opposition, persecution, and calumny, to maintain and develop the same.

Let all the nations rise and call him *blessed*.

THE USE OF ICHTHYOL.—Niemirowsky.—He reports brilliant results in the treatment of chronic para- and perimetritis; ovaritis was but little relieved, and in salpingitis, endometritis and erosions the treatment was unsuccessful. Its soothing and absorbing properties were marked, but pruritus was sometimes produced. Massage was necessary to remove all products of inflammation in many cases.—*Centralblatt für Gynäkologie*, No. 23, 1892.

MUCOUS POLYPUS OF THE NOSE.

BY JOHN N. TAYLOR, M.D., CRAWFORDSVILLE, IND.,

President Indiana State Board of Health.

(Read before the Indiana Institute of Homoeopathy, May, 1892.)

WITH more or less of frequency patients apply to physicians who suffer from obstructed nostrils, with the concomitant symptoms of mouth breathing, dry throat, hacking cough, sneezing and sometimes pain in the chest, asthma more or less pronounced, frontal headache, facial neuralgia, etc. The nasals are all eliminated from phonation, there may be excoriation of the *alæ nasi*, and almost always there is an odor from the nostrils like that which arises from a nest of young mice.

An examination with a good reflecting glass and speculum under favorable circumstances will quickly show the cause of all the discomfort suffered, one or more bodies occupying more or less of the anterior nasal cavity and looking strangely like a blue point oyster will be found more or less bathed in mucus. The patient may, by forced inhalation or exhalation through the nose, draw back or thrust forward these bodies. If a probe be wrapped with a film of cotton and brought in contact with one of these tumors it will be found that it is more or less soft and movable and attached by a stem to one of the turbinated bodies, more frequently the middle or lower.

As to the cause which produces myxoma, it is said that they are not due to any underlying dyscrasia; neither syphilis nor scrofula have anything to do with them, nor may a deviating septum bear a causal relation, but when it coexists it is rather as an effect than a cause. Chronic inflammation of the Schneiderian membrane is perhaps the most common cause, though any persistent irritation of the turbinated bodies may result in an over-stimulation of cell development, and finally in polypus.

Differential diagnosis is usually not difficult. Mucous polypus is differentiated from hypertrophy by its gelatinous character, and its mobility and softness. It cannot be confounded with papilloma, fibroma, cystic enchondroma nor osteoma, if its characteristics are borne in mind. While hypertrophy is the result of an increase in all the cell elements which compose the turbinated bodies, myxoma is a result of over-stimulation applied to the submucous, mucous and

epithelial structures, hence the resultant mucine which composes the bulk of the neoplasm, the small amounts of connective-tissue proper, and the almost total lack of bloodvessels and nerves, save at the points of attachment to the turbinated bodies, when the supply may be considerable.

Treatment.—To attempt to remove these growths by remedies administered internally is to insure disappointment. The constitutional disturbances manifested are but reflexes of the local irritation, and will cease with the removal of the growths. If any such should remain after the removal of the exciting cause they may be proper subjects for constitutional treatment, but until the cause of these reflexes has been removed we can hope for little good from constitutional treatment. Such remedies as *calc. carb.*, *kali iod.*, *sanguinaria*, etc., may have a place in the treatment of myxoma, but it is at this end of the trouble. If the tumor be small and does not present much obstruction to respiration, it may be treated successfully with daily applications of tincture of chloride of iron, or by injections with a 50 per cent. solution of carbolic acid, either of which will under favorable circumstances, cause it to shrivel in a longer or shorter time. If, on the contrary, the tumor is large and the obstruction to inhalation considerable, the treatment should be prompt and radical, therefore, surgical. For the purpose of removing the growth nothing equals the cold wire snare. A loop of piano wire drawn through a canula and attached to screw or slide, after the manner of Bosworth, Sajous, Jarvis and other snares, being a proper device. I use a Griffin's modification of Bosworth, which I find very efficient. The size of the pedicle should determine the rapidity with which the wire is drawn through the tumor. If the pedicle is thick and vascular it should be drawn slowly, if otherwise, quickly.

Myxoma are prone to recur, and many measures have been tried to prevent this. Dr. Harrison Griffin informs me that for this purpose nothing equals absolute alcohol applied daily to the stump for several days after the operation. Spraying the nasal cavity with liquid vaseline or benzoinol, to keep the nose clear of irritating secretions, is a successful after-treatment.

LAPAROTOMY FOR DIFFUSE, PURULENT PERITONITIS—Krecke.—The best results are obtained in puerperal peritonitis. There is abundant evidence that peritonitis is no longer a *noli-me-tangere* to the surgeon, and many lives have been saved by laparotomy for this disease. The writer urges the use of the knife when the signs of diffuse, purulent peritonitis are present.—*Centralblatt für Gynäkologie*, No. 23, 1892.

UTERINE HÆMORRHAGES.

BY R. E. HINMAN, M.D., ATLANTA, GEORGIA.

It has been my duty during the past few years to attend professionally several cases of uterine hæmorrhage. As I have been unvaryingly successful in controlling them, it has occurred to me that a brief recital of the treatment employed may be of interest to some medical brother, and also alleviate, in some degree, the sufferings of womankind. While I do not pretend to the introduction of any startling innovation, nor to any very new method, I do contend that it is of great practical value.

CASE I.—Mrs. A. I was called hurriedly, the messenger stating that she was “flooding” dangerously. I found the patient lying down, face pale and drawn, skin moist and cool, pulse feeble and rapid, voice low and weak. Stated that her usual menstrual period had come on the day before, but the discharge had been fitful though painless. The following morning she found it had been very profuse during the night, weakening her considerably. Had risen and tried to perform her usual household duties, but the discharge had become more and more profuse, until it “gushed like a pump,” as she expressed it, soon becoming so exhausted that she was compelled to lie down. She gave a history of previous attacks of similar character, though none so violent as the present one.

After removing the clots, I found, on examination, a pale and flabby vaginal canal, soft and patulous os, and an enlarged, partially prolapsed subinvolted uterus, which was oozing a continuous current of blood. I washed all clean with warm water from a fountain syringe, then used hot water against the os, but with no effect; then astringent solutions, vinegar, gave ergot, etc., but the flooding still continued, the patient growing weaker meanwhile. Then, in my extremity, I packed the vaginal canal, through a speculum, with cracked ice. This caused a cessation, so I gave a solution of millefolium and left, thinking all was well. In a few hours I was again summoned, and found the hæmorrhage almost as bad as ever. Then I thought of the faradic current and determined on its usage. I placed one electrode over the abdomen and the other against the os. I found the patient could stand quite a strong current without pain or discomfort. I kept it up for about five minutes and had the satisfaction of noting a complete cessation of the hæmorrhage on re-

moving the sponge. Tamponed the vagina and continued with the millefolium. I called again in about four hours and found everything was in good order. Next morning I noted a very slight return of the flow, but did not interfere aside from keeping up the internal medication.

When the immediate danger was over I put her on china and ferrum met. 3x, and she made a good and rapid recovery. Between the periods I treated the uterus locally by applications of iodine and glycerine and by tampons of boroglycerine, and occasional applications of the faradic current. Up to this time, two years after, she has had no return of any dangerous menorrhagia.

CASE II.—Mrs. B. Was a case of abortion at the third month, accompanied by profuse hæmorrhage, the uterus refusing to contract after the expulsion of the foetus. Drugs and the usual local remedies were tried without effect, the hæmorrhage continuing in an alarming manner. I applied the faradic current, but placed one electrode over the lumbo-sacral region instead of the abdomen, and the other at the os. After turning on the current the uterus contracted firmly and the hæmorrhage ceased. A slight discharge remained for about a week, the patient making a good recovery under the usual treatment. As in the previous case there was a decided tendency to menorrhagia from a chronically congested uterus, but she refused to undergo any local treatment.

About a year afterward I was called to attend this same patient in a case of labor at full term. Remembering my former experience I took my battery with me. The labor was a tedious one from inefficient pains, they being feeble and irregular from the poor physical condition and lax muscular fibre of the patient. After five hours of waiting and encouragement, supplemented by two and three drop doses of ergot every half hour, then two and three grain doses of quinine, the child was born, and in due time the placenta also. As I had followed the fundus with my hand and felt it retract as the labor progressed, I felt no uneasiness. After the placenta was delivered, and at the request of the patient a bandage applied, I crossed the room to examine the child, which was being attended by the nurse. I had probably left the bedside for five minutes when I was startled by the mother crying, "O, doctor, I'm flooding so bad!" And she was, profusely. Off came the bandage, and I felt for and grasped the fundus, the uterus feeling as large and distended as if holding a five months' foetus, for it was filled with blood. Removing the clots with one hand I pressed the fundus with all my strength

with the other, when "pschut!" a gush of clotted blood, and the uterus contracted. But the hæmorrhage continued, though lessened. Directing the nurse to press down on the fundus, I got my battery in order and applied the current. The result was completely satisfactory, and the patient's recovery as good as could be expected.

CASE III.—Mrs. C. In this case there was a very bad history. Of three previous pregnancies, the first had resulted in premature labor at the eighth month, followed by a very dangerous and troublesome uterine hæmorrhage, which fitfully reappeared during the following three months, the patient being confined to her bed and unable to nurse her child. The second resulted in premature labor at seven and a half months, bad hæmorrhage and confinement to bed for two months. The third was abortion at the third month, dangerous hæmorrhage, fitfully reappearing for two months or more, and kept the patient in bed for over three months. Previous to existing pregnancy she had been troubled with menorrhagia at different times, which though competently treated, had not been cured. When she came under my care it was for an existing menorrhagia, though she stated at the same time she thought she was again pregnant. While her belief and condition seemed at direct variance with medical lore and all classic physiology, still a woman who has passed through three pregnancies has a rather definite knowledge of the subjective symptoms of this condition. I made no local applications but prescribed such medicines as gave her relief, placing but slight confidence however in her belief of pregnancy. In three weeks the menstrual flow again appeared, lasting several days; four weeks later they again appeared but very lightly. After this there was no reappearance until delivery of the child, for she was pregnant, and the pregnancy did date from the time of the profuse menstruation she consulted me about. I was asked to take charge of the case about the seventh month. Great care was necessary several times to prevent a miscarriage. A few days after the beginning of the ninth month of pregnancy I was summoned to attend her in labor. The labor was a very tedious one; the pains being short, sharp, very painful and very ineffectual. This condition went on for several hours, when I attempted to apply the current to stimulate contractions, but she objected so strenuously that I desisted. I delivered the child with forceps after waiting eight hours. The placenta came away nicely, but the uterus would not retract firmly, and the old condition of affairs seemed about to ensue. I at once used the battery contracting the uterus down firmly, until it felt

about the size and consistency of a baseball. She remained in bed only twelve days, after which she attended to her usual household duties. Four weeks after the delivery of the child she rode a bicycle, five weeks after, she rode one five miles without unusual fatigue. Her health has been better than that following any of her previous pregnancies, all of which she ascribes to that "wonderful little battery," and I, in a measure, agree.

CASE IV.—Mrs. D. This last case was one of retained placenta. I was called four hours after the birth of the child, and found the case in charge of a midwife who had become alarmed at her failure to deliver the after-birth and had sent for me. There was a complete absence of pains and had been for three hours. Bimanual manipulation failed of any effect, even when supplemented by traction on the cord. I then applied the faradic current, to which influence the uterus promptly responded by delivering the placenta intact. Ergot had been given in full doses prior to my arrival. I kept the current on for about three minutes, the uterus contracting firmly. A good recovery resulted.

I would add but little comment to these related cases, for they speak for themselves. They cover the greater part of the ordinary emergencies of uterine hæmorrhage. The efficacy of the method will, I think, commend itself to all who once try it. It is the simplest and most physiological method of inducing uterine contractions, being free from the bad effects that may follow the use of drugs. Another fact in its favor is that the annoying symptom of after-pains is lessened by its usage, also it decreases the tendency to subinvolution. It is my habit to always follow the delivery of the placenta with an application of the faradic current. It is good preventive treatment.

While I know there is nothing new in this method, still I hope it may be of help to some. So much is brought into better use by teaching "line upon line," etc. The battery used was a small "closed cell" charged with bisulphate of mercury and water. It is easily portable in an obstetric bag, inexpensive, and requires little care to keep it in order.

PREGNANCY AND VENTRAL FIXATION OF THE UTERUS.—Fraipont reports three cases of ventral fixation followed by pregnancy. One went to full term and two others to seven and a half months, when premature labor occurred as the result of abusive treatment. Considerable pain was experienced in the early months. Fraipont suggests a gradual stretching of the adhesion between the fundus uteri and the abdomen which may result in a cord-like formation which might be called a middle round ligament.—*Centralblatt für Gynäkologie*, No. 13, 1892.

RUBELLA.

BY DE FOREST BAKER, M.D., CLEVELAND, OHIO.

(Read before the Ohio Homœopathic Medical Society, May 10, 1892.)

ALTHOUGH rubella is a disease of frequent occurrence, very little is written of it in our text-books. We often hear of German measles, false measles, and many other terms by which this disease is commonly known, but rubella is undoubtedly the proper term for this rose-red colored eruptive fever.

There is but little doubt that rubella is directly contagious, and it is more prone to be epidemic than either measles or scarlet fever; also that it occurs independently of the existence of either of these diseases. Therefore it is not a hybrid disease, but like other eruptive fevers, it is produced by the reception into or upon some part of the system of the pre-existing specific poison or contagium. One attack usually protects from subsequent invasion, but will not protect the patient from either measles or scarlet fever.

Rubella occurs chiefly between the ages of three and twelve years. It may be met with in infants, rarely adults, and, like other eruptive fevers, it is characterized by stages of incubation, invasion, eruption and decline, and so closely resembles measles in many instances and scarlet fever in others, that it becomes necessary to differentiate between it and these diseases.

Here the history of the patient is of great importance. Has the child ever had either scarlet fever or measles? Are either of these diseases existing epidemically? The stage of incubation is very variable, from four to twenty-one days, thus differentiating from the fixed period of measles. The invasive stage is usually of short duration, from twelve to twenty-four hours. The catarrhal symptoms, if present, are ordinarily slight, contrary to those of measles, while there is nearly always present a sore throat and an eruption upon the fauces, which precedes the cutaneous eruption, and may be complicated with some of the forms of stomatitis.

The fever in this stage is slight and vomiting does not often occur. Either in this, or the eruptive stage, may be noticed one of the most characteristic or diagnostic features of rubella, viz., enlargement and induration of the cervical, post-cervical and post-auricular glands. Occasionally only a few of these glands may be effected, but more often the entire chain, also the lymphatic glands in other parts of the body, may be involved.

The duration of the eruptive stage is usually shorter than that of measles or scarlet fever. The eruption may first appear like the eruption of measles, upon the face, but spreads more rapidly over the surface, or it may appear over the whole surface at once. It may rapidly fade in one part and appear in another. In color it is of a pale rose-red, but not so red as scarlet fever, nor so bluish as measles.

Over the more vascular parts it is often slightly elevated, with a tendency to become confluent. In other parts it is more maculate in form and of a much higher color in the centre; nor do we have the characteristic odor so peculiar to measles. The pulse and temperature in this stage is more variable than that of measles or scarlet fever, nor does it seem to be in direct relationship to the eruption.

The tongue is usually slightly coated and cleans in patches, producing the so-called "maped tongue" but never the "strawberry tongue." Desquamation is slightly branny, and follows the eruption in nearly every case. In some cases it is well marked; in others, however, it may only be observed on some particular parts, as about the nose, and may last for twenty days or more.

MATERNAL IMPRESSIONS.

BY MILTON J. BLIEM, M.D., SAN ANTONIO, TEXAS.

THE subject of pre-natal impressions upon the foetus is one of perennial interest. A recent clinical lecture by Dr. Parvin, published in the *International Medical Magazine* for June, brings fresh confirmation to those who believe in the theory. We who hold to this opinion are in good company with such authorities as Montgomery, Rokitansky, Carpenter, Dalton, Flint, St. Hilaire, Allen, Thomson, Hammond, Meadows, Spitzka, Busey, Dabney, Border and Parvin!

I think it worth while to record the most striking case of this kind in my own experience. About a year and a half ago I attended Mrs. D. in her second confinement. I had also assisted her in her first labor, which was very severe, requiring instrumental interference; there was a severe perineal rupture, which was at once repaired. The child was perfectly formed and is to-day a fine girl of 3 years. This, the second labor, was very easy and without any incident or accident. The baby, also a little girl, was perfectly

formed, and weighed $7\frac{1}{2}$ pounds. While performing her first toilet it was noticed that the index, middle and ring fingers of the left hand were entirely missing; the little finger was represented by one phalanx, but the thumb was perfect. Over the site of the middle finger was a miniature nail growing out of the skin. I later removed the nail and adjacent skin, but evidently failed to secure all the matrix, for it returned and projects sharply to-day.

The mother at once offered an explanation which to my mind is perfectly satisfactory. When about three months gone she was one day busily running her sewing machine, when her little girl crept up behind the machine and presently succeeded in getting her hand caught in the revolving wheel, severely hurting her. The mother was, of course, greatly shocked and alarmed, thinking at first that she had crushed the child's fingers off completely. Whether it was the left or the right hand of the child she could not positively remember, but naturally was inclined to recall that it was the left. Be that as it may, I consider this case a strong proof of the effect of that mother's sudden and violent impression upon her forming child.

RECENT EXPERIENCE IN THE TREATMENT OF DIPHTHERIA.

BY W. J. MARTIN, M.D., PITTSBURGH, PA.

(Read before the American Institute of Homœopathy, Washington, D. C., June 16, 1892.)

THE object of this paper is to report the cure of cases of diphtheria with *tarantula cubensis*, and to define the sphere of *tarantula* in the treatment of diphtheria as demonstrated by clinical experience. Not every case to which it was given recovered, for I think we all must admit that some cases of diphtheria are doomed from the beginning. A child of feeble physical organization, if overpowered with the diphtheritic poison will die, and that, too, sometimes in a day or two from the outbreak of the disease. A few weeks ago I was called on a Wednesday afternoon to a puny boy, aged six years, whom I had been informed had not been well for a few days. He was dressed and lounging about in an easy-chair. An examination revealed a case of diphtheria of such gravity that I at once concluded it would be fatal, and so informed the parents—to their great surprise. The next day at noon he died. Such a case with two days' start was not amenable to any treatment.

My attention was first called to *tarantula cubensis* in the winter of 1883 by an article in one of our journals by Dr. Samuel Freedley, of Philadelphia, where he says: "All homœopathic physicians are well aware that aconite will cure an acute inflammatory fever in a very short time, say in eight or ten hours, but that it is of no avail in diphtheria. *Tarantula cubensis*, I have found, will cure diphtheritic fever in its highest forms with delirium, in about the same time that the former remedy cures acute fever, and if given at the proper time rarely wants any other medicine to perfect the cure." At the meeting of the Pennsylvania Homœopathic Medical Society, in 1884, I reported a series of cases of diphtheria in which *tarantula* had been used. Several of these cases are so typical of the class to which *tarantula* is applicable that I will reproduce them here.

On January 5, 1884, I was called to a boy, æt. five years, presenting all the inflammatory symptoms usually present at the outset of an attack of diphtheria; the face was fiery red, the head and body was hot with a pungent heat, the child was drowsy and started in sleep as though frightened, the throat was swollen and inflamed and both tonsils covered with membrane; from the mouth came very distinctly the odor of diphtheria. *Tarantula c.* 12 in water, one teaspoonful every two hours was prescribed. The next morning there was improvement in every respect and on the third morning he was well.

On the morning of February 5, 1884, I was called to see a boy, æt. five years, of light complexion and nervous temperament. He had gone to bed the previous evening well, but during the night became feverish and flighty, vomited and complained of soreness of the throat. When I saw him next morning both tonsils were much swollen and well covered with membrane. The appearance of the throat, the violence of the onset of the disease, the high temperature and the vomiting all led me to consider this a very serious case. I prescribed *tarant.* 12 in water, a dose every two hours. The next morning he was so much better that I could hardly credit it; he had rested well all night. I made in all but four visits and discharged him well. He took no medicine but the *tarantula*.

April 7, 1884, I was called to see a young lady of sixteen. Both tonsils were swollen until they almost touched and were covered with a thick yellow membrane. Swallowing was difficult, the neck greatly swollen, fever and flushed face. *Tarant.* 12. Next day throat no worse, but headache and fever better. *Tarant.* was continued. On the third day the throat symptoms remained about the same as described; there was also considerable pytalism and a heavy yellow coating on the base of the tongue. The *tarant.* was now stopped and *merc. iod. flav.* 3 prescribed, a dry powder every two hours. On this remedy the throat cleared up promptly and she made a good and rapid recovery.

While this young lady was under treatment, three younger children were taken down with the disease. One of them, a girl of twelve, received the treatment above noted, viz.: tarant. followed by mere. iod. flav. The two youngest ones recovered on tarant. alone. All four were severe cases.

Sixteen cases, all treated with tarantula and all recovering, are described in this report to the Pennsylvania State Society. From that time to the present no remedy is so frequently used by me in diphtheria as this one. It is always my first prescription, provided I am called immediately, or very soon after, the onset of the disease, and the case is one of the sthenic type.

The initiatory febrile symptoms calling for tarantula correspond exactly to, and are entirely covered by, belladonna, viz.: the flushed face; pungent heat; throbbing carotids; jerking; starting out of sleep in a fright; spasms, etc., but when we recognize the case as one of diphtheria by discovering the membrane or detecting the odor, it is a serious mistake to waste valuable time giving belladonna. That profound student of materia medica, the lamented Farrington, said: "There is, strictly speaking, no resemblance between the belladonna inflammation and that characteristic of diphtheria. The general character of diphtheria is that of blood-poisoning, while belladonna does not poison the blood. If you give belladonna in diphtheria, therefore, be certain that it is the remedy, or you will lose valuable time."

Tarantula cubensis is one of that class of priceless remedies peculiar to our school, obtained from the animal kingdom; it is an animal poison. It is a congener of apis, lachesis, crotales, etc. Of the animal poisons Farrington says, "We look upon these poisons as medicines which suit deep-seated diseases, such for example as are accompanied by changes in the quality of the blood; such as profoundly affect the nervous centres. The whole tendency of these remedies is to produce diseases always of a destructive form, tending to local as well as to general death of the body." In their application to diphtheria there is a well defined difference in the class of cases to which either apis, lachesis or tarantula is suitable. Apis and lachesis are called for in cases where asthenia is prominent, whilst tarantula suits cases of a marked sthenic type. In apis we have great debility and prostration from the start, suspicious absence of heat, not much fever, no thirst, etc.

With lachesis we find asthenia from the start, intense pain accompanying an apparently small amount of inflammation. As Dunham

puts it, "the constitutional symptoms are out of all proportion to the local manifestations." Membrane commences on the left side. With tarantula the onset of the disease is sudden and violent; there is intense febrile excitement; as a rule the patient is thirsty, sometimes for small drinks often, and sometimes for large drinks often; anorexia; sometimes vomiting; usually they complain of soreness of throat and painful deglutition; occasionally they do not complain at first of any soreness of the throat and have no difficulty in swallowing; as a rule both sides of the throat are affected uniformly. The following case illustrates the suddenness of the attack and the violence of the onset.

September 27, 1891, was called early in the morning to a child of about three years who had been put to bed the evening before in good health and spirits. During the night he awoke sick, vomited, became very hot, complained of pain in the head and throat and stomach, was drowsy and stupid, yet would start up every little while as though frightened, cry a little and again become drowsy and stupid. The surface of the child's body felt intensely hot. I saw him about six hours from the beginning of the sickness; he was very hot and flushed, pupils contracted, both tonsils very much enlarged and both covered by a firm yellow membrane having the color of chamois skin. Prescribed tarant. 12 a dose every hour and called again in about fourteen hours, when I found the febrile symptoms all very much modified, and the condition of the throat pretty much the same as in the morning. The remedy was now given every two hours. For two days more he took the tarant. steadily improving, and then improvement ceased. Now merc. iod. flav. 3 was prescribed on account of the symptoms presented by the throat. Improvement again set in and continued steadily, so that I had the pleasure of dismissing the case on the seventh day.

At the time this child was sick there was prevailing a very fatal type of diphtheria in the section of the city where he resided. So violent was it that several of this child's playmates had died within forty-eight hours of their taking sick. Three other cases in this neighborhood came under my care; all made rapid recovery on tarantula. This was noteworthy from the fact that cases treated by others either died or made very slow recovery.

I might describe a great many more cases, but think I have now said enough to make clear the sphere of tarantula in diphtheria as I have found it by continuous use during a period of eight years. It is frequently necessary to supplement it, after the first two or three days, or when improvement ceases under it, with some other drug.

Most frequently one of the iodides of mercury, sometimes kali bi. or kali mur. or lycop. or any remedy indicated.

The cases that made the surest and quickest recovery were those that received the medicine almost immediately on the setting in of the disease. Those who did not recover were, as a rule, cases in which the disease had one, two or more days' start. I have two cases now under treatment; one is doing very well, the other is not doing well; both are taking tarantula. The case that is doing well, and it was the most violent case too, I saw in five or six hours after it took sick. The case that is not doing well had been sick thirty-six hours when I first saw it. So great is my confidence in the power of this drug to cure diphtheria of the variety I have tried to describe, that I feel as though there should be no deaths from this much dreaded disease, if recognized at once and tarantula cubensis in the sixth, twelfth or thirtieth potency immediately prescribed.

ANTISEPSIS: A REPLICATION.

BY GEO. B. PECK, M.D., PROVIDENCE, R. I.

AN elaborate criticism in the August number of the *HAHNEMAN-NIAN MONTHLY* of certain opinions alleged to be held and to have been promulgated by me occasions the first violation of a rule adopted at the very commencement of my professional life: Never allow yourself to be drawn into a journalistic discussion! The importance of the subject and its issues, however, forbids silence. The elegance of that review I cannot hope to attain, for more practical duties have prevented special attention to polite literature since I commenced preparing for college thirty-five years ago. Should my language seem blunt remember that I was a soldier long before I dreamed of being a physician, and that it is difficult to eradicate the roughness of camp-life when one revels in its experiences. I deeply appreciate the kind personal allusions of Dr. T. L. Macdonald, and beg to assure him of my most friendly regard.

The entire critique is based upon a single statement as a foundation. On page 557, lines 2-4, of the current volume, it is alleged, of my report to the American Institute, that "the central theme appears to be the deprecation of antisepsis in its relation, not alone to obstetrical surgery, but to general and gynecic surgery as well."

Having shown, however (page 484, lines 14-19), just what a homœopathist is, according to the *Century Dictionary*, which is *authority*, and that (page 485, lines 8-11) no relation subsists between surgery and homœopathy, although the same individual may practice both, precisely as some do practice homœopathy and pharmacy, or homœopathy and theology, and, furthermore, having already clearly stated my subject to be the relation of *homœopathists* to the germ theory, it is a mystery to me how that conception could have originated. The fact is, not the slightest allusion is made to antiseptic surgery or to aseptic, either general, obstetrical or gynecic, in my entire article, nor do I see how I could more plainly have excluded them without seriously impairing the unity of my argument. Still that may be but an additional proof of my literary incapacity.

So far as the establishment of a principle is concerned it *is* a matter of the *completest indifference* whether one or fifty-one species of schizomycetes have been proved the cause of human diseases. The extent of applicability is a very different question from the nature of essence. All who are familiar with both well know that the demonstration of the germ theory is immeasurably more complete than that of the nebular hypothesis, but whoever heard of an astronomer objecting to the popular designation of La Place's brilliant conception? Each term indicates a recognized fact in natural science, nor is a single doubt implied by the use of either.

Before the puny babe bacteriology had half established its right to exist gossip friends (?) framed a system for the prevention and the cure of fleshly ills based upon her first feeble utterances. The promptness and the thoroughness with which homœopathists tested that system is ample proof of their lively interest in all things pertaining to the welfare of man. Had their experience been reported two years earlier it would not have varied a percentum from that so recently published. Then, however, it would have been accounted by the world indisputable evidence of the stupidity, ignorance and prejudice of the new school. But lo! bacteriology has burst its swaddling clothes and standing forth in the full strength and vigor of youth, independent of conceited interpreters, authoritatively speaks of disease and death and their relation to myriad swarms of microbes. With her latest utterances the American Institute stands in hearty accord, vindicated alike in its conservatism and its integrity. Elsewhere, then, than among its true-hearted members must we search for "absurd, unreasonable and ridiculous" theorizers

concerning the treatment of microbic as well as of *parasitic* diseases.

Since the subject of my investigation was the relation of *homœopaths* to the germ theory it would have been singularly improper to call surgeons as a class to the witness stand, for only as they combine in their persons with their specialty the functions of the homœopathic physician can they have practical knowledge of the matter. The general practitioner, and he who occasionally serves as such alone are competent to testify in the premises, and their statements only were collated. From them must be learned all that can be learned, all that can be known on this subject—disqualified is each and every other anticipated witness. The breadth of the evidence submitted is not the least important guarantee of its accuracy and reliability. It is the source of its authority.

Every reader of the HAHNEMANNIAN will be as much surprised as myself to learn that F. Mitchell Prudden, M.D., Professor of Pathology in the College of Physicians and Surgeons, New York City; Alexander C. Abbot, M.D., practically head of the Institute of Hygiene of the University of Pennsylvania, Philadelphia; and Wm. H. Welch, M.D., Professor of Pathology at Johns Hopkins University, Baltimore, are “three bacteriologists whose opinions are adverse to germ infection,” but that is what my critic affirms, page 564, line 1. It is true the gentleman did not know the identity of those concerning whom he made that assertion: hence he should not have ventured upon it. Because I did not see fit to indicate my authorities, he evidently believed them third class specialists and their testimony almost worthless. The habit of swallowing unquestioningly any statement linked to a brilliant name, forgetful that the author may have been drunk, joking, insane, or misrepresented is one of the heaviest weights that cripples the progress of the old school while the new has by no means escaped its baneful influence. Every declaration should be judged by its subject-matter and not by adventitious accompaniments.

An explanatory analysis of my report is now in order although undertaken with the emotions one experiences when called upon to explain his best joke. Having announced my theme, I first ascertained what homœopaths are and what the germ theory is in common parlance. For that purpose I consulted the *Century Dictionary* which is recognized authority (except when it decides against us). Then I found what proportion of the former have considered the latter theoretically and the conclusions they arrived at. Next I

discovered that only in one particular can homœopathists *as such* have any practical relations with the germ theory. Again it became necessary to refer to the *Century Dictionary* for the exact signification and proper use of words. But so loosely are technical terms often employed by the profession, it seemed necessary to particularize what acts are included in given classes that the accuracy required by scientific discussion might be secured. Observe that ordinary cleanliness is distinctly stated to be a sub-class of aseptic instrumentalities: whether the introduction of that distinction was wise or not may be an open question. They who deem it unwise can find no difficulty in combining the experiences under that head with those under asepsis. The personal experiences were introduced as a balance page to the boastings of our regular brethren. We are quite as neat in our ministrations as they, a fact which can readily be established by figures if any one will trouble himself to collect them. I regretted the presence of the word tomfoolery in one of the testimonies, but I could not suppress it without materially altering the statement, which I did not feel at liberty to do. My critic devotes much attention to this man's first three hundred cases, but studiously ignores the succeeding six hundred treated with ordinary cleanliness. Having summarized my results for ready remembrance or convenient reference, two salient facts demonstrated thereby were particularized. Then the course of procedure finally adopted by the great bulk of our practitioners, the entire omission of strong chemical douches by at least 33 per centum and their occasional employment by not less than 45 per centum more, was vindicated by the unbiased, because unsolicited testimony of three leading American bacteriologists. The evidence of the last two was published less than six months prior to the drafting of my report: that of the middle one was certified to me as correct to date by the first in a private letter on April 13, 1892. If any inaccuracy is discovered therein settle it with these masters of their profession. Two practical lessons impressively enforced by the antecedent facts conclude the paper.

Two remarks on the critique of my report and I am done. Repeated perusals have but strengthened my first conviction that never before did its author read a professional paper half so carelessly, else he never could have attained his present creditable position. On no other hypothesis can its numerous gross misconceptions of my statements and my opinions be accounted for. This, too, after I had explicitly stated that one reason why I read my paper by title only was, because it was not intended for a single cursory reading, but rather for

careful perusal in the library. (Of course, I *pretend* to use English accurately and perspicuously!)

Again, if my brother had read with his *wonted* care, "Some Considerations Concerning Antiseptic Surgery," an address by Professor Welch before the Clinical Society of Maryland, October 16, 1891, and printed in the *Maryland Medical Journal*, November 14, 1891, he never would have written "Antisepsis Generally Speaking," for there he would have found the grounds of the declarations of my third witness. The paragraph containing this evidence was prepared after my report had been elsewhere completed and copied, so late did its existence come to my knowledge. Yet general acquaintance with the trend of surgical literature had satisfied me that the day of antisepsis, *properly and strictly so-called*, had passed, and I was deeply gratified to find my opinion confirmed and the causes of its decline definitely set forth by a gentleman whom a bacteriological expert at my elbow affirms is the highest authority in such matters in the United States. Eminent though he be in his specialty, however, as a practitioner I am compelled to differ from him in that I *clearly* see the *marked* "advantages of using the term aseptic surgery in the sense in which it is generally employed at the present time as something distinct from antiseptic surgery." The representative of a school whose *regular* drug prescriptions are poisonous doses just small enough to avoid immediate disagreeable toxic effects, cannot be expected fully to appreciate the noxious and complicating results of (to them) weak applications of irritant and caustic substances to mucous membranes and living flesh. I am quite ready to admit that "the substitution of heat for chemical substances in the disinfection of instruments, ligatures, dressings, etc. (including douches, G. B. P.), is an important advance," and that it is, in fact, "only the substitution of a more powerful for a weaker antiseptic agent;" but, so long as the established good usage of the English language remains unchanged, such an application of terms as is referred to is misleading to the great bulk of the profession and to the entire body of the laity. One of the greatest evils pervading medical literature is the loose and inaccurate employment of words and phrases. Such a custom would affect general literature immaterially, but in technical circles it is paralyzing. Doctors do not exert much influence in the framing of their mother tongue, but they should strive to conform thereto, especially when posing as instructors in the classroom, on the platform, or in print.

JOTTINGS FROM ACTIVE PRACTICE IN OLD ENGLAND.

BY ROBERT T. COOPER, M.A., M.D., LONDON, ENGLAND.

Physician, Diseases of the Ear, London Homœopathic Hospital.

(Concluded from page 103.)

WHILE on the subject of ozone, it is not easy to say what are the indications for benzoic acid, beyond that the cases in which it has given assistance were ones in which the characteristic odor of ozæna was very marked, and the patients pale and ill-nourished.

Benzoic acid is one of those remedies, the curative powers in which are much expanded and added to by dilution. The friend of an amateur homœopath whose practice was very extensive among the neighboring poor, told me that this gentleman had had most astonishing cures from high dilutions of benzoic acid in cases where the urine had all the appearance of icteric urine, and where, besides this, other symptoms of jaundice were present; indications that, of course, are loose, but may be helpful. And, in a case lately under me, of an old debilitated man of seventy, where pain existed down the middle third of the right side of the trunk, with tightness across the diaphragm, swollen stomach, pain in the chest and between the shoulders, fluttering, flatus being constantly passed; symptoms that existed along with a foul, dirty mouth, feverishness, coated tongue, and high-colored, thick urine; benzoic acid in the 3d dec. aggravated for two days, and then brought about the most complete relief.

Benzoic acid would seem to be indicated in dirty, fetid conditions of the mouth, where quantities of tartar exist upon the teeth, and the breath smells impure and heavy.

For many of these symptoms *ferrum picricum*, in dilutions runs it close, but the benzoic acid mouth is more generally foul, and in every way dirtier.

It is very observable how searchingly derangements of the liver are corrected by well-indicated remedies. Within the last few days, I happened to meet Dr. Harper, of Mayfair, in the street, and, in course of conversation, remarked to him what a powerful hepatic action all the remedies I have proved to be useful in deafness possessed. Well, said he, that reminds me of a remarkable experience of my own; I had a gentleman under my care, past middle age, who had had a cataract in one eye for some twenty years, with which

he was completely blind; he had occasion to consult me for hepatic derangement, for which I prescribed a low potency of podophyllum. In a few days, he returned with tears of gratitude, declaring that the medicine had not alone done his liver trouble good, but that light was distinctly entering his eye, and this continued until the cataract entirely disappeared.

Just about the same time, when visiting a patient, Dr. Harper learned that Dr. David Wilson, of Brook Street, had restored the sight of an old lady afflicted with cataract, and accordingly he called upon Wilson to hear the particulars. After the usual greeting, the following dialogue took place:

"Well, Wilson, I hear that you have been curing a lot of blind people, and that you are coming out as an eye-doctor."

"No, never; who told you that?"

"Well, don't you know Mrs. So-and-so, that you cured of cataract?"

"Oh, aye, yes; true enough; I did cure her, but it was by a fluke. Her liver symptoms pointed to podophyllum, and I gave her a high dilution of it, when, lo! and behold, her old cataractous eyes cleared, and the sight returned in a way as wonderful as it was unlooked for."

Dr. Harper then recounted the like experience he had had with podophyllum, and the satisfactory way in which it had cleared away an old dense cataract, so dense that no ray of light could enter the eye, and yet, that within eight days of commencing the use of a low potency of podophyllum, it entirely disappeared.

The podophyllum, Dr. Harper has since informed me, caused a rapid dispersion of the whole thing, so that, within the short space of time of eight days, he saw as well with one eye as with the other.

Our old friend, David, on hearing of this, threw himself back in his chair and rubbed his hands with sheer delight.

The coincidence of two old cataracts being cured, the one with a high dilution, the other with a low one, of a remedy which, like podophyllum, in no way seemed in relationship with cataract is not a little remarkable, and well deserves further investigation.

Chelidonium, too, the hepatic action of which much resembles that of podophyllum, has for ages been in repute as "a sight clearer," and a *χελιδον* or swallow is said by Pliny to have discovered this property; hence its name.

Some years ago a young man, a patient of mine, told me a dog of his had gone quite blind after severe conjunctivitis; both corneæ be-

came quite white. Hearing that sulphate of copper was of use as a collyrium he put a few grains in a tumbler and sponged his dog's face and eyelids with this. None of the solution appeared to find its way inside the eyelids, and yet the opacities of both eyes quite cleared off and the dog regained his sight perfectly. Remembering this I prescribed the third dec. trit. 15 grains to 2 drachms of vaseline, to be applied externally, to a case of most obstinate constantly recurring keratitis with 'opacities, and it has had the effect of lessening the amount of opacity and of preventing a recurrence of inflammation. Before using it the patient had never known a severe cold to be unattended with inflammation of the eyes; now she still takes cold but it never affects her eyes. The inference from this would be that if we are to use external applications in eye cases, the lids are sufficiently absorptive for all practical purposes, and that applications to the external lids rather than to the conjunctiva ought to be encouraged.

This calls to mind that some years ago I went into the shop of a working cutler; my eyes at the time were rather inflamed, and observing this our friend, the cutler, proceeded to dilate upon the method adopted "in the trade" for dispersing inflammation of the eyes.

In grinding cutlery the men's eyes are constantly becoming inflamed from the entrance of the gritty particles given off from the steel blades into the eyes, and the consequent constantly recurring irritation of the conjunctiva.

Often and often, said he, have I had my eyes inflamed frightfully from this cause, and what I should have done without the remedy I and those about me employ I cannot tell; what we do is this: we get some fresh water cresses, bruise up roughly and apply the coarsely pulped leaves and stalks to the external lids on lying down at night.

The effect of such an application is to produce a good deal of heat and smarting of the eyelids, which lasts some five or six minutes; the water cresses may then be taken away and the lids be dried with a soft cloth. The sufferer then goes to sleep and wakes in the morning without a particle of inflammation left, or at least with noticeable improvement.

This was our friend the cutler's testimony; it is my own; and it is the testimony of numbers of persons to whom I have recommended it and who were sufferers from gouty conjunctivitis.

In gouty conjunctivitis attended with "granular lids," and where

the eyelids are thickened and dusky-red in color, the water-cress poultice gives great relief.

It may be supposed to act as a simple rubefacient ; I hardly think so and for this reason. A member of my own household suffered for some weeks from an inflammatory state of the eyelids that showed itself specially on getting up in the morning, but which continued troublesome day and night. I advised the water cress application, but instead of using it as directed, a sprig of water cress was placed in a basin of water over night, and the water thus influenced by the water cress was used to bathe the eyelids and eyeballs in the morning. This proved almost immediately remedial, and the result was entire subsidence of the inflammatory tendency.

SOME VERIFICATIONS OF REMEDIES.

BY H. M. BUNTING, M.D., NORRISTOWN, PA.

(Read before the Homœopathic Medical Society of Delaware, Chester, and Montgomery counties, Pa.)

WHO of us is not familiar from daily experience with the aggravation from motion of bryonia, the relief by it of rhus, the nausea of ipecac in distinction to that of the antimonies. The mental dissimilarities of puls., ign., and platina, and in the treatment of our cases have again and again verified these and many more well-known modalities. It is not to these, however, that I wish to call your attention to-night, but rather to take up and discuss some symptoms which I have confirmed in remedies that with me have been but infrequently used.

Abies nigra or black spruce, in its application for the treatment of dyspepsia gives us the feeling as if one had swallowed some indigestible substance, which had lodged at the cardiac end of the stomach, the "*hard boiled egg*" symptom of our text-books ; with this we have the low-spiritedness and the constipation incident to dyspepsia. On several occasions I have relieved this and kindred sensations of a lump or weight in the stomach by this drug. Puls. and china have the sensation of food sticking behind the sternum, higher up than the abies. Nux, bismuth, calc. c., bry., kali c., arsen., zinc, ign., sep., phos., sulph., and nat. mur. all have pressure in stomach after eating more or less, but I know of no remedy which has the peculiar symptoms above mentioned, so clearly defined as the abies.

Acetic acid was of use to me once in a severe diarrhoea of phthisis after other remedies had been given and failed. I checked the flux to a normal condition by this remedy on the symptom recorded in Hering, diarrhoea with swelling of legs and feet.

Aethusa cynapium, or fool's parsley, has rendered valuable aid in the diarrhoeas of children and in cholera infantum, with the symptom so forcibly impressed on us by Farrington in his lecture, child vomits chunks of coagulated milk, falls asleep exhausted and awakens hungry, the milk is often thrown up in green masses; this with a yellow or green mucous stool is quite characteristic of the remedy. Ant. crud. and calc. c. are its nearest analogues in vomiting.

Antimony presents vomiting of milk with white coated tongue, almost as if whitewashed; irritability, does not want to be looked at.

Calcareo has vomiting of milk in thick curds, but we have, as distinguishing from *aethusa*, the *calcareo* child with its general build, complexion and sweats.

Agaricus muscarius has been of special service in the burning sensation of frost-bitten members; each spring the patient complains of severe soreness and burning in the parts which was speedily relieved by the above remedy. I have verified on more than one occasion the symptoms, restlessness, tossing about the bed to get the scattered members of his body together, found under *baptisia*; this is a different restlessness from *rhus* or *brionia*.

Lachnantes has aided me in the relief of stiff or wry neck, where the head was drawn to one side or where on turning the head pain was experienced in the nape of the neck as if dislocated; this stiffness may be of catarrhal or rheumatic origin. It rivals bell., *rhus* or *nux* in *torticollis*.

You have before heard of my preference for *nuphar lutea* in the treatment of early morning diarrhoea with smarting in the anus, weakness of the limbs and general exhaustion. We have also for early morning diarrhoea prominently, aloes, bry., nat. sul., pod., and sulphur.

Thuja in the cure of a morning diarrhoea was once to me of special service; the patient complained that the movements were only on the days on which she ate breakfast; doing without this meal gave immunity from the diarrhoea. Her teeth decayed very early.

Tuberculinum has greatly relieved the cough of a phthisical subject, given at the time more empirically than otherwise, yet with a marked improvement in the whole condition; with gain in weight and strength and abatement of night sweats.

In conclusion let me briefly cite a case which I cured in a, to me, thoroughly Hahnemannian manner. A man about 35 years of age, a miller by occupation, came to me several years ago with alopecia, the hair coming out in spots size of a half dollar over the head, with a growing in around the margins of the spots of gray hair, much itching of the scalp. *Vinea minor* 200, in about three weeks cured the condition entirely; he received no other treatment.

I have thus tried to recall some verifications which are to me of much interest, believing as I do that if we can sufficiently individualize our cases and remedies the homœopathic drug will bring the desired result in curable cases without a doubt.

NITRITE OF AMYL VERSUS CHLOROFORM.

BY J. C. CUMMINGS, M.D., ST. LOUIS, MO.

READING the notes on "Nitrite of Amyl," by J. Crichton Browne, F.R.S.E., in Braithwait's *Retrospect*, Part lxx., January, 1875, it occurred to me that nitrite of amyl might be an antidote to chloroform. Dr. Browne, when administering nitrite of amyl in cases of stasis epilepticus, noticed that the patient yawned profoundly and repeatedly. Dr. Browne says, that "nitrite of amyl always, when inhaled, hastens and deepens breathing." (When inhaled, it acts immediately as a powerful stimulant to the heart, more powerful, indeed, than any other known agent; and a little of it, applied to the nostrils, causes an instantaneous and extraordinary flushing of the face; given to animals, by inhalation, it is capable of suspending respiration, and producing death; but short of the latter result, it may produce, when properly regulated, a reduction of the respiration and circulation so extreme, that a condition analogous to *trance* may be induced and sustained for many hours.—See *U. S. Dispensatory*, Edition of 1870.)

Dr. Richardson says, that nitrite of amyl, though it is capable of producing insensibility, is attended with a kind of "consciousness." Still, may not Dr. Browne have used it homœopathically, without being aware of the fact. I would suggest to those who use chloroform often to take with them nitrite of amyl, and when alarming symptoms occur to soak, at once, a piece of lint in nitrite of

amyl and cautiously let the patient inhale a little, from time to time, until natural respiration is restored.

As a *dernier ressort*, may it not be useful as a remedy in still-born infants—diluted in either alcohol or ether—and injected up the nostrils, or on the face, as a spray?

CORRESPONDENCE.

A METHOD FOR CONTROLLING SPASMS OF THE GLOTTIS.

EDITORS HAHNEMANNIAN MONTHLY:

While resident physician at the Hahnemann Hospital of Philadelphia, I was called on the evening of August 7th to the bedside of an hysterical young lady, who had been admitted on August 3d, suffering with neuralgia of the left ovary. The patient's pulse and respiration had become weak and rapid, the former 92, the latter 53. The temperature was 99.2. The usual stimulants were applied and while watching for their effect I noticed that her chest had suddenly ceased to rise at all. The intercostal and infra-clavicular spaces deepened, the sterno-cleido-mastoid muscles became rigid and prominent, the head thrown back, eyes rolled upward and the hands clutching at the throat. Surmising a spasm of the glottis, I slapped the chest, applied ice to the chest, gave inhalations of aromatic spirits of ammonia and tried artificial respiration, but with no result. In my efforts to shorten the spasm I tried a method the novelty and success of which leads me to submit it to the profession.

Opening her mouth I thrust in my index finger and touched the epiglottis. She gagged and the spasm was over. During the next two hours she had eight more spasms each resembling the first but they all were instantly controlled by this simple method.

Drop doses of tincture of moschus each in one teaspoonful of water were then administered under directions from Dr. Mohr, in the absence of Dr. Bartlett. She had a spasm fifteen minutes after the first dose, but no others for three days. On the evening of August 10th, she had another attack, and on the evening of August 17th, she had a very severe attack. All of the spasms, while not prevented, were immediately stopped by touching the epiglottis.

EDWARD ROLLIN GREGG, M.D.

EDITORIAL.

THE HOMŒOPATHIC MEDICAL SOCIETY OF PENNSYLVANIA.

THE next annual session of the Homœopathic Medical Society of the State of Pennsylvania will be held at the Hahnemann Medical College, Philadelphia, September 14th, 15th, and 16th, 1892. The Philadelphia physicians, looking forward to this meeting, and recognizing the fact that questions of vital importance to the future of homœopathy in Pennsylvania—the establishment of a Medical Examining and Licensing Board, and the necessity of making some provision for the insane desiring homœopathic treatment—will rightly bring to the city every member of the profession in the State, whether a member of the society or not, who has any regard for the success of homœopathy, have taken unusual steps to provide for a successful meeting. The large number of papers already reported by able and well-known writers, assures the success of the scientific department, and the daring and persistent attempts of the allopathic physicians of the State to establish restrictive medical legislation during recent legislative sessions, has thoroughly aroused the profession to zealously guard her inherent rights and interests; consequently, this being the year for the legislature of the Commonwealth of Pennsylvania to convene, the legislative branch of work will occupy an unusual degree of importance; as the benefit of this labor falls upon all, it demands the best thought, effort, and co-operation of every member of the profession in the State. The social side of the meeting will also be of unusual scope; a large and enthusiastic committee of the Philadelphia County Society has, for weeks, been actively at work formulating and perfecting plans for the entertainment of the members of the society and their friends visiting the city with them. The old and worn-out formality of a banquet will be abandoned, and on Thursday evening, September 15th, a reception will be held at St. George's Hall, with music, refreshments, and every other feature necessary to make the evening pass pleasantly and socially. On one of the days, the visiting members and their friends will be taken a carriage-ride in Fairmount Park and along the lovely Wissahickon; and other features are contemplated, so that visiting physicians need not worry about the members of their families accompanying them finding the time spent in the city wearisome, and they can give their undivided attention to the business of the society.

THE NEW OPTICAL COLLEGE AND ITS LESSONS.

THE Philadelphia daily papers announce that the courts have permitted the filing of an application for a charter for the Philadelphia Optical College without reference to a master. The object of the new institution is to furnish instruction in optical principles and the correction of defects of vision by glasses. Nothing is said as to the character of the students to be taken, from which we infer that the institution is not to be one especially designed for post-graduate instruction, excepting as some physician chanced to find his way into its halls of learning.

We are sorry that the attempt to start a school of this character has been made. Unless its students are limited strictly to those thoroughly posted in general medicine and all its collateral branches the college can only lower the medical standard in the State of Pennsylvania. We are also sorry, because this attempt at what we regard as a blow at professional honor, finds one, at least, of its supporters in a homœopathic physician in good standing and of unblemished reputation.

Specialism has been gradually lowering itself in the estimation of the profession, owing to the fact that so many men, too lazy to study medicine in its entirety, become specialists. Now, this new college will encourage the wildest sort of specialism. It proposes to teach optics and the correction of defects of vision by glasses. Its students learning nothing else will fall into the very natural error of considering *all* visual defects as the result of refractive errors, and they will act accordingly. They will possess no knowledge of general ailments and their influence on the eye. Without a knowledge of medicine they cannot handle the ophthalmoscope with even slight skill.

If it is the intention of this college to educate jewellers and optical peddlers in the art of refraction, we think it is foisting on the defenceless public a lot of illegal practitioners. We are well aware that it has been claimed that the optician who prescribes glasses does not infringe our medical registration law; but so it is said of the counter-prescribing druggist. If the optical college has a legitimate field in teaching refraction, then another new college will be needed to teach midwives the art of treating uterine displacements by pessaries. Colleges of this character can be multiplied without number; and with what result? Simply that of lowering the pro-

fession in the eyes of the public. We sincerely hope that our friends will not start their optical college.

From a selfish standpoint they should refrain, because if jewellers, peddlers and other laymen can treat defective vision by glasses, then medical men are not necessary. We deny that any but a medical man can correct refractive errors with safety.

It has only been in recent years that physicians generally have recognized the importance of sending all their cases of eye trouble, which they themselves could not treat, to the oculist. But little more than a decade ago, they were just as likely to send them "around the corner" to the nearest spectacle vender.

It is our experience that but few opticians and no jewellers, are capable of properly doing the mechanical work of filling the oculist's prescription. The more thoroughly, therefore, the eye is kept under the supervision of physicians the better.

If it is the intention of the projectors of the new college enterprise to confine their labors to the instruction of post-graduates, we gladly welcome it. Otherwise, we express most strongly our disapproval.

An entirely irrelevant subject has been suggested by the above remarks; one, however, of such importance, as to lead us to refer to it here somewhat in extenso. Just as it was once the custom for physicians to refer their patients to opticians and jewellers for glasses, so now it is very common for them to send their cases of hernia to the druggist or truss manufacturer. Such a course is folly in the highest degree. If they with their medical education do not understand hernia and the application of trusses, how can they expect the instrument maker to be any better posted. The ignorance of the latter makes him bold to attempt cases, that only the most skilful and experienced should handle. What is more, the confidence ill-placed in him by the doctors, flatters his vanity; and vanity and ignorance make a dangerous combination, and this we have found developed to a high degree in certain truss dealers whose sole aim is to defame the medical profession and exalt their own importance. This evil can easily be corrected if physicians will but study the practical application of trusses to hernia and superintend the work instead of leaving it entirely to the mechanician. We once heard a large retail surgical instrument maker say that the average doctor knew absolutely nothing about trusses. We hope that this slander will be lived down.

ENTERPRISE IN BAD TASTE.

A HOMŒOPATHIC physician of world-wide fame died about ten years ago. Within a few days after his death, many, we might almost say all, homœopathic physicians received a circular announcement from a prominent insurance company to the effect that a certain sum of money had been received by the widow, said sum of money representing the amount of the policy held by her husband in that company. A hypothetical letter from the widow accompanied the circular, which letter we have since been assured was not only "hypothetical" but genuinely fictitious.

The same insurance company subsequently sent out notices that three eminent physicians, who were mentioned by name, had taken out policies for \$50,000 each in that company. This only goes to show the care with which prominent men must make every action, however apparently trivial it may appear to be. Dr. John X. Jones can insure where he pleases, and his widow can enjoy the fruits of his forethought without public annoyance; but the eminent Prof. ——— must have his private affairs heralded broadcast all over the country. We cannot see that a company deserves any credit for paying its policies promptly. That is its contract.

We received this day a circular from an enterprising manufacturer of a dietetic preparation, which doubtless is worthy of professional confidence; but we think he has transcended the limits of propriety in sending this circular broadcast as he has probably done. This circular consists in the first place of a fac-simile of an autograph letter ordering for the wife of an illustrious American one and a half-dozen bottles of the advertiser's preparation. On an inside page of the circular is a testimonial from the physician in charge of the case. We feel confident that any such use of this letter in relation to a private case is entirely unwarranted by said physician. The heralding broadcast of affairs that belong only in the sick room is decidedly demoralizing. We may go farther, and say that it is utterly devoid of common sense. The Hon. Mrs. Blank's dyspepsia is no more aristocratic than is that of a plebeian Mrs. Blank. We see no reason therefore why persons of prominence should not be permitted to enjoy their misfortunes and die in peace like ordinary mortals.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D.,

FRANK H. PRITCHARD, M.D., AND EDWARD M. GRAMM, M.D.

FALSE ANGINA PECTORIS IN THE MALE.—Dr. Alexander Peyer, of Zurich, Switzerland, calls attention to the diagnostic points of spurious angina pectoris in the male, for it may be confused with true angina pectoris:

1. True angina pectoris appears chiefly in the age of arterio-sclerosis, *i.e.*, after the fortieth year, while spurious angina is limited to no special age, yet one may say that it appears oftener before the fortieth than after this age.

2. In true angina, the attacks are brought on by movements which are accompanied by exertion. In spurious angina, the attacks appear spontaneously. They set in periodically, frequently at the same hour or day, and during the night, especially.

3. The character of the pain is different in spurious angina. The patients complain of a feeling as if the heart were squeezed between two things, of a tearing feeling in the heart, of a feeling in the heart as if it were too large, of tension, girdle sensations, etc. The attacks, as a rule, last longer than in true angina; the intensity is not so severe, as a rule.

4. False angina is often complicated with other nervous symptoms, as, for example, spinal irritation, confusion of the head, irritability and depression, irritable bladder, and anomalies of the sexual sphere.

5. The entire clinical picture is that of a nervous disease.

6. Naturally, the condition of the heart plays an important part in the diagnosis of genuine angina. Preceding affections of the heart are of great importance in this regard, the chief amongst which are:

Chronic myocarditis, which often follows pericarditis and endocarditis, and which when present is always accompanied by arrhythmia of the pulse.

Fatty heart, developing during chronic alcoholism, poisoning by phosphorus, arsenic, and general obesity, etc.

Sclerosis of the coronary arteries, which is accompanied by general arterio-sclerosis of the vascular system. An aneurism of the ascending aorta can press upon the cardiac plexus, and produce attacks of genuine angina pectoris. Pressure upon its branches will produce an attack.

When the affection is accompanied by neurasthenic symptoms and an organic heart affection can be excluded.

7. The history of the case offers us important elements in judging of the character of the disease. If one can find that the patient is suffering, from hereditary entailment, congenital weakness of the genito-urinary organs, if he masturbated in his youth, has chronic gonorrhœa, frequent emissions and spermatorrhea, practices interrupted coitus or venereal sexual excesses in any way, then one would think of the nervous form of the disease rather than the organic form, especially if the heart is normal. The chief causes of this affection are anomalies of the genital system, which substratum is a posterior urethritis. In other words, the majority of the patients suffering from nervous or false angina pectoris, are also suffering from neurasthenia, and this symptom is only a more or less prominent symptom in the clinical picture.

Hereditary nervous entailment is only demonstrable in a very small minority of the cases. The age of most of the patients is from 20 to 30 years. One of the writer's patients was 15 while another was 52. With regard to the treatment, it varies with the cause. In the majority of the cases it is a mere symptom of sexual neurasthenia, therefore the treatment of the angina is the treatment of the neurasthenia.—*Wiener Medicinische Presse*, No. 27, 1892.

THE DIGESTIVE FERMENT OF THE CARICA PAPAYA IN GASTRO-INTESTINAL DISORDERS.—For more than a century it has been known that the milky juice of

the papaw has the power of softening meat, and it is still in general use for this purpose by the natives in the West Indies and some districts of South America. The carica papaya is indigenous to the southern portion of this continent. It bears a large melon-shaped fruit, turning yellow when ripe, containing a great many seeds, the pulp having a not disagreeable taste, except that, according to Rossbach, it slightly suggests the odor of turpentine. The trunk of the tree, the leaves and the fruit all contain a milky juice, which rapidly undergoes a fermentative process. If alcohol be added to this milky juice, the digestive ferment will be precipitated, and to this the name "papain" was given by Wurtz and Boucluit. Finckler, of Bonn, devised a process for the purification of papain. This preparation, known in this country commercially as "papoid" is a fine cream-white powder, almost devoid of odor and taste, freely soluble in both water and glycerine and is claimed to be of uniform digestive activity.

The physiological actions of papoid as a digestive agent have been thoroughly established. It acts upon albuminoids, hydrating them and converting them ultimately into peptones. It converts starch with great promptness, the ultimate product being maltose. It emulsifies fats. Moreover, Herschell declares that it has a direct tonic action upon the stomach, stimulating the secretion of gastric juice or pepsinogen. It is also antiseptic in its action and prevents abnormal fermentative processes from taking place in the stomach and intestines. It acts at all temperatures, but attains its maximum activity at 130° F. It acts best in alkaline solution, but can work also in fluids with an acid or neutral reaction. It is freely soluble and is most active when in a concentrated form. It has no action upon living tissue and is positively innocuous when swallowed in any quantity that is likely to be administered.

Experiments made by Woodbury show that papoid can digest readily the constituents of a dinner of bread, meat, potatoes, peas, mince-pie.

The uses of papoid in treating disorders of the digestive organs may be summarized somewhat as follows:

1. In actual or relative deficiency of the gastric juice or its constituents.
 - a. Diminished secretion of gastric juice as a whole.
 - Apepsia.
 - Anæmia and deficient blood supply.
 - Wasting diseases.
 - b. Diminished proportion of pepsin.
 - Atonic dyspepsia.
 - Atrophy of gastric tubules.
 - c. Diminution of hydrochloric acid.
 - Achlorhydria.
 - Carcinoma.
 - d. Relative deficiency of gastric juice.
 - Overfeeding.
2. In gastric catarrh.
 - a. When there is tenacious mucus to be removed, thus enabling the food to come in contact with the mucous membrane.
 - b. Where there is impaired digestion.
3. In excessive secretion of acid.
 - To prevent duodenal dyspepsia.
4. In gastralgia, irritable stomach, nausea and vomiting.
5. In intestinal disorders.
 - a. In constipation due to indigestion.
 - b. In diarrhoea as a sedative.
 - c. In intestinal worms, by removing the mucus by which the worms are shielded.
6. In infectious disorders of the intestinal tract.
 - a. Where there is abnormal fermentation.
 - b. Where there are foreign substances present, its detergent effect may be utilized in cleaning out the *débris* from the intestinal contents by digestion.
7. In infantile indigestion; here papoid not only readily peptonizes cows' milk, but the resulting curds are also soft and flocculent.

The dose of papoid is ordinarily one or two grains, but five grains or more may be used.—*N. Y. Med. Jour.*, July 30, 1892.

MENINGITIS FROM PNEUMOCOCCI AND MENINGITIC SYMPTOMS IN PNEUMONIA.—Dr. Hutinel had a child under his care who died of meningitis of pneumonic

origin. Excepting meningitis of tuberculous origin that due to pneumococci is next in frequency. Anatomically this form is well characterized. The exudate is yellowish, concrete, of the color of mastic and predominating in the intervals of the convolutions of the brain, yet it may cover the entire surface of the hemispheres. The purulent exudate is found along the vessels as spots or stripes as if traced with a painter's brush. It may also form true plaques or a continuous network. The convexity of the cerebrum is the seat by predilection but the base as well as the spinal membranes may also be invaded. In the latter case the posterior portion of the cord near the cervical enlargement or the lumbar enlargement is attacked. In tuberculous meningitis the ventricles are usually dilated and their walls softened, while in this affection the ventricular effusion is less abundant, and only the choroid plexus is thickened and transformed into yellowish masses, resembling flaps of tissue undergoing suppuration. At the same time lesions of the same origin are found in the lungs, endocardium or other serous surfaces. The pus in these cases is thick and consistent. The symptomatology of this disease is not well fixed. It is found in certain subjects who are in a very comatose and prostrated state in the last days of the disease. In other cases the disease develops with a rapidity so great that the patients succumb with apoplectic symptoms. Death may appear in a few hours. It is not rare to find that these patients have fallen in the streets, die and be transported to the Morgue. The symptoms vary according to the seat and extent of the lesions. It often begins quickly, the temperature rising rapidly to a great height, the pulse frequently becoming slow as in tuberculous meningitis. The periods of remission are wanting however, and the symptoms are especially prominent. Indeed, they are almost tetanic in their rigidity and to be compared with those seen in epidemic cerebro-spinal meningitis, which is usually a disease of pneumococcic origin. There are delirium, agitation, hallucination, etc., and all the symptoms of meningitis of the convexity. When with these symptoms a herpes appears the diagnosis is rendered easier. When the lesions are situated chiefly at the base, the picture is but little different from that of the tuberculous meningitis. If an inflammation of the nose, throat, ear, lungs which is of probable pneumococcic origin the diagnosis is indicated but it is well to be reserved. This disease generally terminates in death yet recoveries have been recorded. It generally follows a pneumonia, endocarditis or pericarditis. Pneumonia is not an indispensable cause of the meningitis but only the most frequent cause. The prognosis is very different in a pneumonic condition and true meningitis. In certain cases the meningitic symptoms are obscure and of not much importance, while in others they are predominant. There are certain forms where it does not come to suppuration and these are the ones where the prognosis is less gloomy. Besides true purulent meningitis there is in pneumonia a false meningitis of severity. Direct infection from the throat, nose, ears or sinus is usually followed by purulent meningitis of great gravity. In young children the outlook is better and one should not be too hasty in making a fatal prognosis, in patients from five to fifteen years of age. Sclerose en plaques are said to follow these cases hence the lesions must be material.—*La Semaine Medicale*, No. 32, 1892.

SALOPHEN IN ACUTE RHEUMATISM.—Salophen, or acetyl-para-amydosalol, occurs in the form of white, crystalline scales, almost insoluble in water, more soluble in hot water, but fairly soluble in alcohol and ether, particularly with the aid of heat, and is without taste or odor. Experiments made by Guttman seem to prove that salophen in doses of from sixty to ninety grains a day, exerted an undoubted favorable effect upon acute rheumatism. The four cases described by him were discharged cured after eighteen, nine, ten and ten days, respectively, while relief from fever, pain and swelling of the joints was obtained in about two days in each case. The results were not, however, always as favorable as in the cases cited. In some cases even salophen had little or no action.

Dr. William H. Flint has used salophen in his service at the Presbyterian Hospital, New York. In six cases, the drug was administered in fifteen-grain doses every three hours. A cure was effected in periods ranging from six to sixteen days. Pains were relieved, the redness dispelled and the temperature reduced to normal on the second or third day of treatment. In none of the cases was the heart's action at all weakened, nor was digestion impaired by the remedy. No relapses occurred and no complicating endocarditis, pericarditis or pleuritis appeared. From these facts, Dr. Flint concludes that we possess in salophen a remedy equally potent as the other salicylates to control the symptoms of acute rheumatism, but devoid of

their tendency to weaken the heart's action, to disturb the stomach, and to produce albuminuria and smoky urine. The author has also tried salophen in a number of cases of chronic rheumatic arthritis with very poor average results, although there have been one or two notable exceptions to this general rule. — *N. Y. Medical Journal*, July 30, 1892.

AN OBJECTIVE METHOD OF TESTING SENSIBILITY IN TRAUMATIC NEUROSIS.—Goldschneider maintains that in cases presenting local or general hyperæsthesia, the perception of thermal stimuli is also involved. His researches have further shown him that the method of estimating the topographical temperature sense, devised by him a few years ago, is an adequate gauge by which the truth of a patient's statements regarding the existence of anesthesia can be determined, consequently it is especially useful in traumatic neurosis or hysteria.

In deciding between actual and feigned analgesia or hypalgesia, he recommends the following plan: A large metal plate is used as the indifferent electrode, the other electrode is a long wire brush connected with the cathode of the induced current, and is placed in such a manner that half the length of the brush rests upon unaffected skin, the remainder on the part said to be numbed. The secondary coil is then adjusted until pain is obviously produced. While continuing this current, the electrode is slightly raised from the normal side without letting the patient recognize the manœuvre; cessation of pain naturally results if the skin remaining in contact with the electrode be analgesic. — *Supplement to the British Medical Journal*, July 23, 1892.

THE CAUSES OF BAD BREATH.—Dr. Kjellman, of Stockholm, Sweden, calls attention to the importance of not neglecting to examine the respiratory tract in treating cases of bad breath, especially in chronic diseases. The acute affections, accompanied by necrosis of tissue, are not included here. The cause of bad breath generally lies in the respiratory passages, nose, larynx, pharynx, trachea, lungs, or buccal cavity. This is naturally in contradiction to the generally accepted teaching that the chief cause of bad breath is the stomach. The œsophagus is a tube completely closed, at least in its upper part, and only open when food passes. Chronic stomach diseases, by the consequent changes in the mouth and pharynx, are, of course, to be thought of. The changes in the respiratory tract are due to putrefaction, and, in all cases, an examination of this tract is to be recommended.

1. *Scrofulous in Children with Chronic Catarrh.*—Here an insipid and disgusting smell is observed, which is discovered by the odor of the handkerchief used. The nasal cavity is found filled with a stagnant, purulent, and stinking mucus. The mucous membrane is hypertrophied, and chiefly at its lower part. This may be regarded as the forerunner of ozena.

2. *Ozena.*—A strikingly bad breath is a sign of the presence of ozena, either in the nose, naso-pharynx, pharynx, or trachea. The mucous membrane is generally covered with dried, greenish-yellow or whitish masses of secretion. It is soft, and dries quickly, and hence cannot be expelled by blowing the nose or coughing. After its removal, atrophy and contraction of the mucous membrane and the adjacent parts takes place, from which the nasal cavity is apparently enlarged. In ozena of the nose the naso-pharynx is also involved. Less frequently, the trachea is attacked, or larynx. The secretion from the upper parts of the larynx may be expelled, but those crusts lying beneath the vocal cords persist in their place to give off the characteristic ozena stink. This is due to the presence of a micrococcus. As soon as the secretion is removed the odor disappears. It is most intense in youthful patients, and less in older ones.

3. *Nasal Syphilis.*—A disgusting odor may be caused by nasal syphilis, especially in old cases with atropia of the mucous membrane. In cases of ulceration of the bone or cartilage, the secretions stagnate and putrify. The smell is never so severe as in ozena.

4. *Hereditary Syphilis.*—An especially disagreeable odor of the breath is often seen in the children of syphilitic parents. A diffuse atrophy of the dark gray and moist mucous membrane is observed, which is covered with greenish yellow crusts. Ulcerations of the cartilage or bone only will appear some years later. The septum is prone to be attacked by which the diagnosis is confirmed. Only in this case is the ancient term, ozena syphilitica justifiable.

5. *Empyema of the Maxillary Sinus (Antrum of Highmore).*—This gives rise to a disagreeable odor only perceptible in the vicinity of the patient. It is confined to one side; on examination of the nasal cavity the thick, purulent pus is seen to pour

out of the under side of the swollen turbinated bone. The odor is like that of the pus of a gum boil and is very disagreeable to the patient, who—in contrast with *ozena*—had his power of smell intact. Carious bicuspid or molars are found on the corresponding side of the mouth, upper jaw.

6. *Carious Teeth*.—When from the mouth the cause is either carious teeth or the epithelial deposits in the mouth from catarrh of the tongue or mouth.

7. *Chronic Diseases of the Stomach*.—These may be indirectly the cause by being associated with catarrh of tongue or buccal cavity.

8. *Bronchiectasis*.—Stagnating secretions in the lungs, due to bronchiectasis, especially when large, give rise to a terrific odor of the breath on expiration.

Many of these affections are accompanied by other symptoms as pain, etc., which will call attention to the true source of the disturbance, yet in all cases of bad breath one should not neglect to examine the respiratory tract, and above all the nasal cavity.—*Hygiea*, No. 4, 1892.

SYMPTOMATOLOGY AND BACTERIOLOGY OF GONORRHOEAL RHEUMATISM.—Dr. L. Jacquet has studied this subject for the last two years and concludes as follows: The writer agrees with the description of the rheumatismal ophthalmia given by Professor Fournier, but he has observed it more frequently than this author,—six times in twelve cases, four times in six. It preceded the articular symptoms by one or two days. The pain in the heel, first described by Swediaur and sometimes by its persistency becoming an actual infirmity, has not been found to be a constant symptom and, indeed, rare. It is generally attributed to the presence of a retro- or sub-calcaneal bursa. On the contrary, the pains which are located in the fibrous portions, the fibro-cartilages, at the ligamentous insertions and especially those at the apophyses are frequently met with in gonorrhœa, either isolated or associated with other articular manifestations. The pains may be astonishingly persistent. They have been observed to appear in a gonorrhœal patient who had been cured for three years following depressive emotional influences. Amongst their favorite seats are the calcaneal insertion of the tendo Achilles and the plantar aponeuroses; here, properly speaking, is the seat of the gonorrhœic talalgia (heel pain). Yet this is not all, for the writer has seen the calcaneum painful and hyperostatic, in mass, thus producing a considerable deformation in the region of the heel. In two cases out of twelve this was three times that of the normal heel calcaneum. In one of these patients the pain unilateral, had persisted for two years. When last seen the enlarged calcaneum was not longer painful. The second patient presented symmetric osteitis of the calcaneum which had been painful for over a year. There were, besides, in his case, deformations of the toes resembling those of articular arthritis deformans. The tarsal articulations were untouched by the inflammation. This form of osteitis has not been studied as yet. It does not exist without the presence of the gonorrhœa. He proposes to designate the entire complex of the gonorrhœic foot.

3. The predisposing causes and the ætiology of the gonorrhœic arthropathies are still unknown. The French hold that gonorrhœic rheumatism is caused by grafting a gonorrhœa on to a rheumatic diathesis. The writer can not agree with this, as he very rarely found pronounced rheumatic antecedents in the history of the cases, and, indeed, a patient which he examined in the hôpital Beaujon, and who was suffering from acute articular rheumatism, complicated with peri- and endo-carditis. This patient was affected with periodic attacks of rheumatism, lasting every year from the month of October until January, this being his seventeenth attack. He had missed but one attack during this long series of years and that was when he contracted a gonorrhœa.

4. Over-exertion is one and fatigue are the most frequent causes of the disease. In eight cases out of twelve he could trace an undoubted connection. One of these is of especial interest. A vigorous young man contracted the gonorrhœa. He over-worked, taking but two or three hours sleep. A very intense attack of gonorrhœal rheumatism came on of which he was cured, together with his gonorrhœa. Three years later he became a coachman and passed the Christmas week without scarcely sleeping or going to bed. On the 2d of January he was seized with violent articular pains in the hip and shoulder, preceded besides by an intense conjunctivitis. This man thought himself completely cured of the gonorrhœa, while in reality he had the gleet. He asserted that he had not touched a woman for six months and a half. This is analogous to the observations of Amaral and Fournier that old arthrogonorrhœic patients, incompletely cured, are liable to relapses, lightnings up and

a marked recrudescence of their joint affections on the morning after a coitus, even if done with a condom.

5. Bacteriological investigations have revealed but little. Some have found Neisser's gonococcus, others pyogenic microbes, while again others have discovered nothing in the articular fluids. The writer has examined the sero-mucous liquid of four cases unsuccessfully.

6. The ætiology cannot be the same in all cases, for the clinical picture of certain forms, arthralgic form, subacute polyarthritis, the influence of nervous depressive causes in their production or recrudescence, the coexistence of various nervous manifestations, as neuralgias and disturbances of sensation, the frequent absence of micro-organisms in the articular liquid, etc., lead the writer to think that we have here to do with a nervous disease, of the spine in particular, possibly from the action of the urethral micro-organisms, poisons secreted by them. On the other hand, it seems probable that certain forms of gonorrhœal rheumatism are due to Neisser's gonococcus, to a gonorrhemia. Again, pyæmia plays a certain part in their production in certain cases. Besides, it is probable that different forms may combine and obscure the prognosis and lead to the variety in the symptoms. Fournier agreed with Jacquet in the anatomical localization of the famous heel pain (*douleur de talon*). It may be due to an affection of the tendo Achilles, a hygroma or a calcaneal periostitis. He also thinks that gonorrhœal rheumatism leads to deformities of the foot which would be well described by the gonorrhœal foot. The gonorrhœal pains in the foot are very common and, at the same time, the most persistent. In many cases they persist for months, or even years, in spite of whatever one does. It very frequently persists after the urethral discharge has been cured, indeed, the urethral discharge seems to have but little connection with the articular affection. It is known that a large number of cases of gonorrhœal rheumatism appear a long time after the disease has been cured. He has seen several cases where the rheumatism began after the gonorrhœa was cured. He has observed hydrarthrosis appear several weeks after the disappearance of the discharge and after the cessation of all treatment. He does not regard these articular hydrarthroses, nearly always situated at the knee, as the posthumous manifestations of the gonorrhœa, for they are of a varying origin. It is a question whether the gonorrhœic influence does not persist and remain capable of producing articular fluxions. This is rendered probable by the long persistence of rheumatismal symptoms long after the cessation of the discharge. Why is it that the rheumatismal symptoms do not appear at the first setting in of the disease?—*La Semaine Médicale*, No. 30, 1892.

MALIGNANT PRECOCIOUS SYPHILIS.—Dr. Fournier finds that malignant precocious syphilis may manifest itself under two forms:

An isolated form where the malignity is limited to the nervous system.

An associated form where the malignity strikes the nervous system and other organs at the same time.

Dr. Gilles de la Tourette has recorded a case of the first division, while that of the writer belongs to the second.

In a young woman who had been syphilitic for three months and properly treated, there appeared, all at once, a formidable complex of syphilitic accidents, of which the following were the chief:

A confluent, papulotuberculous syphilis, in large plaques and covering nearly the whole body; a hypertrophic onychia, followed by a falling of all the nails of the body; a very intense secondary glossitis; an absolute alopecia of the eyebrows and lashes, with preservation of the hair; severe ophthalmia, double iritis, optic neuritis and choroid-retinitis; absolute blindness for two months. Finally, a complex of nervous symptoms of the greatest intensity, as terrific headache, lightning-like pains in the lower limbs, adynamia, paralytic mydriasis on the left side, multiple hysteric symptoms, etc. Formerly this woman had not presented a single symptom of hysteria. A year was required to get the upper hand over these symptoms by employment of the most energetic treatment, cold baths, sulphurous baths, tonics, change of place of living, country air, a sojourn in the mountains, etc. The reporter points out two points: firstly, that this malignant form was derived from a benign one, for she obtained the disease from her husband, who had only a small chance, a slight roseola, a few palmar eruptions, and one lingual mucous patch. The only element which he can find of any influence in the production of the malignity was that she had previously suffered from malaria. The writer has previously pointed out the importance of malaria as a very important factor in malignant syphilis.—*La Semaine Médicale*, No. 30, 1892.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

SURGERY OF THE GALL-BLADDER.—Parker (New York) reviews the operative procedures at present used in diseases of the gall bladder.

Where the disease or obstruction exists in the cystic duct or gall-bladder, the operations to be thought of are cholecystendysis, cholecystectomy, cholecystotomy with adhesion of the sutured gall-bladder to the abdominal wall, lithotripsy combined with cystotomy, and cholecystostomy.

Where the disease or obstruction exists within the common duct, the operations are choledcho-lithectomy, choledcho-lithotripsy, cholecysto-enterostomy, and a "provisory" cholecystostomy.

Cholecystostomy, or the formation of a fistula connecting the gall-bladder with the integument, is the oldest of these operations. It is too often performed without a clear knowledge of the condition of the ducts, or simply to relieve distension of the gall-bladder. The resulting, long-continued loss of bile often produces emaciation and complete exhaustion, while the position of the adherent organ has caused intestinal obstruction and favors the persistence of a biliary fistula. Performed in two *tempos* it is the safest of all these operations.

Indications: When adhesions to the liver and intestine, or severe hæmorrhage on separating them contraindicate removal of the gall-bladder; when extensive disease of the walls precludes suture of the wound. In the weak and aged it is the only justifiable operation, but in general it should be selected when excision, suture, or anastomosis cannot be practiced.

"*Provisory*" cholecystostomy is indicated as a preliminary step to cholecysto-enterostomy where obstruction exists in the common duct, except from stone, and the patient is exhausted by cholæmia.

Cholecystotomy, with attachment of the sutured gall-bladder to the abdominal wall (Langenbuch), or *cholecystostomy with ligature of the cystic duct* (Zielewicz), are indicated when cholecystectomy cannot be practiced, and when the walls of the gall-bladder are exceedingly thin or very thick.

Cholecystendysis, or dropping back the sutured gall-bladder, has a mortality of one in six, the selection of the operation in the fatal case being acknowledged faulty, however, by the operator.

Indications: Severe cholelithiasis with relatively normal walls of the organ and a pervious cystic duct.

Cholecystectomy.—The mortality of excision has been overestimated, more recent figures showing 20 instead of 50 per cent. (Tait) death-rate. When indicated it is more easily and quickly performed than any other.

Indications: Long-continued and severe cholelithiasis; hydrops due to closure of the cystic duct; marked changes in the walls of the gall-bladder, as from empyema, ulceration, contraction or carcinoma; internal rupture or wounds of the organ when a simple suture is not possible.

Contraindications: Adhesions to the liver and intestines, or closure of the common duct.

Choledcho-lithotripsy, or crushing the stone through the walls of the ducts with the fingers or with instruments, is rarely performed alone, unless the concretion can be crushed and completely pushed into the duodenum.

If the stone is in the cystic duct it is combined with *cystotomy*, the concretion being worked back into the gall-bladder either after crushing or entire. When the stone is in the common duct, it is removed piece meal or intact by *choledcho-lithectomy* with subsequent suture. This operation has been so far successful in the hands of skilled surgeons.

Cholecysto-enterostomy, or an anastomosis between the gall-bladder and a neighboring loop of intestine, has been performed at one sitting, in five cases without a death (Kappeler).

Indications: fistula of the gall-bladder—traumatic, ulcerative, or operative—with excessive secretion; permanent closure of the common duct (except from a stone); perforation of the common duct.—*New York Medical Journal*.

TREATMENT OF CYSTIC TUBERCULOSIS.—I. Bell (Montreal), reports three cases in support of supra-public section in the treatment of tuberculosis of the bladder:

1. Male, age 26 years, suffering for one year with frequent urination, tenesmus, pain at the end of the penis, expulsion of blood at the close of the act of micturition. These symptoms were followed by cloudiness of the urine; they steadily increased in severity and were aggravated by exertion, until he urinated as often as every ten minutes. Urinalysis showed muco-pus, neutral reaction, albumen and about forty ounces of daily secretion. Other measures failing, epicystotomy was performed in the Trendelenburg position and with the Petersen bag. The mucosa was throughout of a deep livid color; about the urethral orifice there was an irregular, superficial ulceration, which bled freely, but was free from induration, showing that the deeper tissues were not involved. The ulcers were canterized with the Paquelin and the bladder flushed with borax and salicylic acid solution. The fistula was kept open for five weeks and healed in three more. At the end of three months all symptoms had disappeared; the urine was clear and normal, and was held for two hours or more; the patient had regained his general health and had increased in weight. No tubercle bacilli were found in the urine, but the case is typical.

2. Male, 33 years of age, with frequent urination and muco pus in the urine for three years. The symptoms had increased markedly for a year, hæmaturia appearing, with incontinence at night. The left testicle and epididymis were enclosed in a hard smooth mass. Epicystotomy showed a condition similar to the above case, contracted bladder, congested mucosa, and superficial ulceration about the urethral orifice. The latter was curetted and canterized with a brilliant result, all the symptoms disappearing. Four months later the testicle was removed, and at the end of a year his condition was almost normal, although the fistula had not completely healed.

Male, æt. 25, presenting the same symptoms which had increased in intensity for five years. The left testicle was indurated and presented two sinuses. Perineal cystotomy and prolonged drainage gave no relief. The symptoms were more severe than in the preceding cases. On opening the bladder the ulceration was found to involve the whole trigone, as well as the region of the urethral orifice, while the entire mucous membrane of the fundus was studded with tubercles. The ulcers alone were scraped and cauterized, and the diseased testicle was subsequently removed. Tuberculin treatment was then instituted, but the patient disappeared discouraged. A year and a half later he was much improved in general health and had gained flesh. The bladder was free from pain, but he suffered from incontinence of urine.

Neither of these patients showed lung or other symptoms of tuberculosis, nor had they ever suffered from venereal disease.

The neck of the bladder is the favorite seat of the disease and it is confined to the mucous membrane, only involving the deeper tissues in advanced cases. The lesions may be primary but are usually secondary to and associated with similar processes in the kidneys or testicles. When general medical and local treatment fail to give relief, and the symptoms render the patient's life miserable epicystotomy should be done without delay. The immediate results are excellent: full relief of the frequent and painful urination and the arrest of the discharge of blood and pus. In the reported cases the remote results too have been very satisfactory.

II. Belfield (Chicago), calls attention to iodine trichloride in cases of cystic tuberculosis. When added in 5 per cent or weaker solution to normal urine, instant decomposition occurs, nascent chlorine and iodine being liberated. The same reaction occurs less rapidly with blood, pus, saliva, etc. It can be kept in stock as a 5 per cent. solution, and a one per cent. solution rapidly sterilizes pure cultures of the staphylococcus pyogenes aureus. The following cases show its value in tubercular cases:

1. Male, age 39, cystic tuberculosis, treated by one per cent. instillations. The frequency of urination decreased from forty minutes to three hours in three weeks. Although the treatment had to be stopped the improvement continued.

2. Female, suffering from cystitis for seven years; urination every hour, urine containing pus and blood; tubercular ulcer, demonstrated by digital exploration, in the upper segment of the bladder. Three injections, during twelve days, of one-half to one per cent. solutions gave marked relief. Two months later the urine could be retained several hours and was passed without pain.

3 and 4. Tuberculosis of epididymis with old fistula treated by hypodermic injections of one-eighth to one-fourth per cent. In both the fistulas healed, after years of existence and the surrounding induration was much reduced.

Iodine trichloride is also a valuable agent in arresting fermentation in the bladder in cases of residual urine from prostatic enlargement.—*Journal of Cutaneous and Genito-Urinary Diseases.*

INTESTINAL SURGERY.—1. *Gastro-enterostomy for Carcinoma of the Pylorus.*—Markee (New York), reports a successful case. A loop of the jejunum was laid against the anterior wall of the stomach, so that the direction of their peristaltic waves corresponded, and their serosa united for about four inches by a continuous suture of silk. The serous and muscular coats were incised and the posterior, free edges of the incisions stitched in like manner. The mucosa was then divided and the two openings united by a circular, continuous suture. An anterior suture of the serosa completed the operation, the anastomatic opening being three inches in length. The whole operation lasted about two hours. The recovery was rapid, and, six months later, the general health was improved, the weight had increased, and the pyloric growth was somewhat larger.

2. *Colo-Colostomy for Annular Carcinoma of the Sigmoid Flexure.*—Markee practiced the same technique successfully in this case. The gut could not be drawn out of the abdomen, and the retro-peritoneal glands were involved. Excision being out of the question, the bulging portions above and below the stricture were united, the opening being nearly three inches long. Recovery was rapid, and the bowel functions were normal a month later when the case was reported.—*New York Medical Journal.*

RADICAL CURE OF FEMORAL HERNIA.—Ruggi (Bologna) proposes a novel method for the treatment of crural hernia, by which he transforms the femoral into an inguinal hernia, and then attempts to radically cure the latter. The crural sac is exposed, freed, and emptied of its contents. An incision is then made along the inguinal canal, which is split, and its posterior wall incised. The hernial sac is drawn into the inguinal opening and tied off, as high up as possible. The two wounds are then accurately sutured, layer by layer. Two cases were operated by this method. The author advocates it because the results of radical operations for the cure of inguinal herniæ are far better than those of the femoral.—*Bulletino della Scienze Med. di Bologna.*

STAB WOUND OF THE ABDOMEN AND INTESTINE.—Jippjakoff (Saratow) reports an unusual case. A drunken woman was seen four hours after being stabbed in the abdomen with a dirty cobbler's knife. Several loops of intestine protruded, and were covered with a stinking mass of feces, urine, and filth. They were cleaned with bichloride solution, the opening enlarged, and the abdominal cavity found full of feces, the small intestine and its mesentery having been wounded. The peritoneal cavity was washed out with boiled water and dusted with iodoform; then, a portion of the intestine, with its mesentery, was resected, and the ends united with a double suture of silk (mucous and serous). Healing was complete in two weeks under two dressings, and the patient made a perfect recovery without febrile reaction.—*Centralblatt für Chirurgie.*

CUNEIFORM OSTEOTOMY FOR FLAT FOOT.—Gerster has obtained good results in five out of six cases. A semi-lunar incision is made on the inner side of the foot, an inch in front of and below the apex of the malleolus, and carried forward for two inches and a half. A wedge of bone is removed piecemeal from the most prominent part of the foot, without regard to anatomical structures. The base of this wedge is on the inner margin of the sole, and the apex on the outer side of the dorsum; it usually includes the head of the astragalus, the entire scaphoid and part of the cuboid. The foot is then broken into shape, and done up in plaster of Paris, in an over-corrected position, without drainage, being kept elevated for a few hours. The method is considered an improvement on the simple Ogston operation, which does not remove enough bone.—*New York Medical Journal.*

PERFORATING TYPHLITIC ULCER.—Hartley (New York) operated a case which closely simulated a perforative appendicitis. It is of interest as showing the occasional occurrence of abscesses in the right iliac fossa from sources other than the appendix. The patient had, for many years, passed diarrhetic stools, the present trouble beginning two weeks previously, with general abdominal tenderness which localized itself in the right iliac fossa. There was neither vomiting nor constipation. The face was septic, respiration superficial, pulse rapid, and temperature 102°. Below

the line from the umbilicus to the anterior superior spine of the ileum was an indistinct tumor which was very tender. The abdomen was moderately tympanitic. Lateral laparotomy showed œdema of the abdominal wall, and, on entering the tumor, a quantity of feculent pus was evacuated. The walls of the abscess were thick, being composed of fibrin and granulation-tissue, and consisted of the cœcum, small intestine, and the peritoneum lining the iliac fossa. The appendix also formed part of this wall, but was healthy. Near its base in the caput coli was a perforation large enough to admit the forefinger. The edges were excised, and the opening closed with fine silk; the abscess cavity was disinfected and packed with iodoform-gauze. Rapid recovery followed.—*New York Medical Journal*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

PUERPERAL ENDOMETRITIS.—Dr. Charles Jewett objects to the use of the curette (though in the past frequently used by him) and the hand. The results are good and the practice safe where the interference is had early, but unsatisfactory when it is late. He is searching for a better method of treatment, and has treated several recent cases with gauze drainage. Dr. Wells calls attention to the value of peroxide of hydrogen for washing out the uterus when it has become septic and after it has been cleared of a large mass of *débris* by the finger. In one case a temperature of 106° was controlled by the peroxide of hydrogen, but not by previous douches of mercuric bichloride. In this case the placenta was retained eight days, and on washing out with a saturated solution of peroxide of hydrogen the temperature came down to normal and remained so.—*The New York Journal of Gynecology and Obstetrics*, April, 1892.

TREATMENT OF HÆMORRHOIDS.—Dr. Gill Wylie says the secret of treating hæmorrhoids without causing much disturbance, and yet securing good results, is to put the needle through in such a way as to simply tie off the mucous membrane. The best local treatment for a hyperæsthetic, sensitive condition of the rectum, is to tie off the hæmorrhoids, cure the fissure, and stretch the sphincter to a pretty complete degree. After each movement, inject a solution of antipyrine, ten grains to two or four ounces of water. Remarkable results will sometimes follow this treatment.—*The New York Journal of Gynecology and Obstetrics*, June, 1892.

ALLEGED GROWTH OF THE PLACENTA AFTER DEATH OF THE FŒTUS.—The primary grafting of the villi on the free surface of the peritonæum is a myth, and so with its discredit the dependent myth of the placental growth after foetal death must disappear. The increased bulk of the placenta is produced only during the life of the fœtus, and not after its death. The extra-peritoneal placenta develops below a serous membrane, which it separates from the subjacent tissues; it is either displaced down and not extensively if the growing fœtus lies above it, or up and extensively if the fœtus lies below it. It is this extra-peritoneal burrowing and displacement that causes the blood effusion and connective-tissue formation leading to the larger bulk of placenta, and it can only happen during active foetal life. The alterations in the structure of the placenta, when extensive, cause the death of the fœtus, and in proportion as these are less profound are the children healthy.—Dr. D. Berry Hart, *American Journal of Obstetrics*, June, 1892.

THE PERFECT FEMALE FORM.—The following are the measurements of the perfect female form as given by a woman eminent in the science of physical culture: Height, five feet five inches; bust measure, thirty-one inches; waist, twenty-six and one-half inches; hips, thirty-five inches.—*The American Journal of Obstetrics*, June, 1892.

CONSERVATIVE TREATMENT OF INFLAMMATIONS OF FALLOPIAN TUBES AND OVARIES.—A. Doleris. The author reports four cases where the conservative treatment as noted in the one case following all resulted in cures, and as at the present time there is so much overzealous resorting to abdominal sections such results are worthy of study.

Case. Mrs. B., æt. 22 years. Commenced to menstruate at 15, regularly, easily and without pain but scantily; at 16 years had dysmenorrhœa without leucorrhœa; married at eighteen years.

The next period very painful and long lasting; vulvo-vaginitis; vaginismus; nervous complications and a separation from her husband after 11 months. At the end of the first six weeks of her marriage a delay of menstruation occurred followed by a discharge so abundant that it was considered as a miscarriage, followed immediately by a thick green-colored discharge with severe pains and colics up to the present time. Upon examination the uterus was immovable and anteverted; the cervix neither large nor long with a narrow external orifice. The vaginal cul-de-sac was crowded with hard masses on both sides, and easily felt through the abdomen, extending into the iliac regions. The tumor was more noticeable on the right side and appeared certainly to be a salpingitis; intermittent fever.

After blisters, absolute rest, glycerine tampons and warm donches, examination revealed a lessening of the serum in the cellular tissue but no decrease in the collection within the tube. Finally the uterus was dilated by successively introduced laminaria tents and finally a sponge tent, all aseptic and antiseptic care being taken and without any bad symptoms resulting. The patient was then chloroformed, the uterus curetted and packed with iodoform gauze and glycerine. In two days the tampon was renewed and the uterus and tumor both found much reduced in size. In three days the cervix alone was tamponed and the following day the pelvis was discovered cleared of the tumor. The cervix was flabby and a red and bloody mucus exuded. The patient was imprudent and three weeks after the curetting an examination revealed a total absence of any tumor on the right side but a large and very painful one on the left, with a generally unsatisfactory state, so that a repetition of the former treatment was instituted with a more complete and thorough surveillance of the patient. Great difficulty was encountered in dilating the uterus. The cervix dilated thoroughly and easily, but above that the dilation was but of small degree and none seemed to occur at the fundus and region of Fallopian tubes so that after a week of these attempts, no change had taken place in the tumor. Believing that the absence of dilation in the upper part of the uterus was the cause of no improvement, the neck was slightly incised and two laminaria introduced carefully to the fundus and kept in place by a tampon in the cervix, and on the following day a sponge tent was introduced. A new examination under chloroform was made and a second curetting of the uterus followed by another drainage, with the result of causing the cystic tubes to entirely disappear.

In two weeks' time there remained no trace of a tumor except an indurated nodule on the left side, which seemed to be the left ovary prolapsed into the cul-de-sac.

The following period was easy and painless and except for the prolapsed ovary which gradually grew less and less sensitive, the patient was entirely well and has remained so for three years.—*Nouvelles Archives d'Obstetrique et de Gynecologie*, 1892.

CONTRIBUTION TO THE STUDY OF THE INFLUENCES OF TREATMENT OF A SYPHILITIC MOTHER, ESPECIALLY DURING PREGNANCY, ON THE HEALTH OF THE OFFSPRING.—George Etienne, 1892. The author refers to the numerous studies already contributed on this subject, and to the conclusions generally accepted that when syphilis complicates pregnancy there may result a premature expulsion of the fetus before viability, an expulsion at term of a dead fetus, or of one who while yet living succumbs shortly to the disease, or in other words that syphilis results in frequent abortions and great mortality to the children. He thinks "that this mortality is even greater in reality than is generally believed from looking over the statistics up to the present time," and that while happily all are agreed as to the benefits derived from specific treatment in preventing abortions, nevertheless as there is considerable difference of opinion among authors on certain details of treatment, that it seems to him worth while to publish certain statistics which demonstrate very effectually the influence of treatment of the mother even to the very moment of her labor in preserving the life of the fetus.

He furnishes statistics under three headings:

1. Syphilis without treatment.
2. Syphilis treated before the pregnancy.
3. Syphilis treated during the pregnancy.

The results as shown by these tables and by the numerous cases reported under the different headings, prove the value of the specific treatment and especially when it is instituted and prosecuted carefully throughout pregnancy.—*Annales de Gynecologie et d'Obstetrique*, 1892.

EIGHTY-ONE CASES OF ECLAMPSIA—Goldberg.—The cases are reported from the Dresden clinic. The frequency of eclampsia was one in one hundred and thirty-three labors. Seven-eighths of the cases were primipara, and in seventy-nine of the eighty-one cases the head presented. Albuminuria was present in ninety per cent., but edema in only fifty per cent. The mortality of the mothers amounted to twenty-four per cent., and that of the children forty-seven per cent. The prognosis was the most unfavorable in pluripara and when the convulsion took place during pregnancy; it was best for convulsions in the puerperal state. The favorable effect of delivery was observed. In severe cases the artificial production of pains or even the bloody dilatation of the cervix was of no avail. Yet the writer recommends emptying the uterus even if pains are not present. Narcotics, hot baths and packs were employed with good results.—*Centralblatt für Gynäkologie*, No. 22, 1892.

THE OPERATIVE TREATMENT OF MYOMAS OF THE UTERUS—Leopold.—If a patient must be operated upon for a myoma which is nearly the size of a child's head, castration or vaginal extirpation can be performed. Castration in general is followed by good results, yet it sometimes happens that hæmorrhages continue when the tumor is submucous. It is not always easy to find the ovaries even though they were supposed to have been felt before the operation; for this reason he prefers vaginal extirpation of the uterus when the vagina is capacious and the tumor not too large, in which case he has opened the cul-de-sac of Douglass, split the posterior wall and removed enough of the growth with Siebold's scissors for extraction of the uterus. He considers the extra-peritoneal treatment of the stump in supravaginal amputation of the uterus far safer than intra-peritoneal treatment, as the abdomen can be quickly closed if the patient is not bearing well the operation. He does not believe in total extirpation of the uterus by laparotomy, as, with a single exception of a myoma developing, he remembers no complaints arising from the cervix.—*Centralblatt für Gynäkologie*, No. 12, 1892.

THE PALLIATIVE TREATMENT OF CARCINOMA UTERI BY ALCOHOL—H. Schultz.—The effect of alcohol on bacteria or albumin led Schultz to inject alcohol into a carcinoma of the cervix uteri; encouraged by the results obtained, he employed the treatment on nine more cases. The injections were made in Sims' position and with the aid of Sims' speculum. The urethral orifice is covered with cotton to protect it from the alcohol. Five to ten cubic centimeters are injected at a time, daily after the first few treatments, which are less frequent. Most of the alcohol injected flows back, carrying with it considerable detritus. Considerable pain is experienced for a short time if the needle is thrust deep into the tissue. The results obtained in the limited number of cases reported are quite encouraging. In two cases the cancers had entirely disappeared, leaving a comparatively healthy surface to all appearance. The writer intends later to publish a more full account of his method of treatment.—*Centralblatt für Gynäkologie*, No. 13, 1892.

THE INTRA-UTERINE INJECTION OF GLYCERINE TO EXCITE UTERINE CONTRACTIONS—Pelzer.—The patient is placed in the knee-elbow or Sims' position and with the aid of a Mercier's catheter fifty to one hundred cubic centimeters of glycerine are injected between the membranes and the uterine wall high up in the uterine cavity above the os internum. The glycerine acts as a direct irritant to the surface of the uterus and contractions begin in one or two hours after using the injection.—*Archiv. für Gynäkologie*, Bd., 42, H. 2, 1892.

THE VESICAL OPERATION FOR VESICO-CERVICAL FISTULA—L. Kleinwächter.—This operation is recommended for vesico-vaginal-uterine fistulæ and uretero-vaginal fistulæ which cannot be reached by the vagina; for vesico-vagina fistulæ with cicatricial stenosis of the vagina in which neither the uterus can be drawn down nor access gained to the anterior vaginal wall; also for very large defects of the vesico-vaginal septum. The operation is performed in Trendelenburg's position. The bladder is opened by an incision two and a half inches long close over the symphysis, extra-peritoneally below the peritoneal fold. The edges of the fistula are freshened and brought together on the inside of the bladder. Catgut is recommended as less likely to cause concretions than permanent sutures. The bladder is closed except space left for a drainage-tube. The external wound (outside the bladder) contains three openings for drainage, the drainage-tube from the bladder and laterally the prevesical space is drained with strips of iodoform gauze. He reports four operations two of which were successful.—*Zeitschrift für Geburtshilfe und Gynäkologie*, Bd., xxiii, H. 2, 1892.

PUERPERAL SEPTICÆMIA.—At the Academy of Medicine meetings on the 1st, 8th and 15th of March, Gueniot reports four cases of puerperal septicæmia when after the minutest investigation he was unable to find any cause, except from the contamination of the surrounding atmosphere and concludes: 1st. In a vitiated atmosphere of an apartment, the poisoned air, whatever may be its source, water closets, sewers, plumbing, etc., may become an active cause of puerperal fever.

2. Mephitic intoxication, *during* pregnancy is brought about through the respiratory apparatus; *after* confinement it results through the bleeding surfaces, in contact with septic liquid or solid matter.

3. The septicæmia which results in this manner is not of a suppurative nature; its chief nidus is in the cavity of the uterus, where, as a result of the mephitic products the septic fibrin appears to find conditions exceptionally propitious for its development.

4. To procure, in this respect, a good prophylactic hygiene, one should insist always upon maintaining the atmosphere of the apartments, pure; to this end, it is necessary not only to see after the cleanliness and ventilation of all parts, the water closets and dressing rooms, etc., but to condemn the plumbing, washstands, etc., and to remedy or to avoid unhealthy drainage of the neighborhood.

These views were combated by several members. Guérin absolutely repelled the idea that germs could enter through the epidermis in the respiratory apparatus, or in any other way than through some wound in the genitals. The fevers always come after confinement where some wound exists. "When a door is open what is the good of asking if a person who is in the house, got in through a window which is closed?"

Charpentier agreed in the main with Guérin, but Hervieux who took part largely in the discussion, agreed with Gueniot, that in certain rare cases one must acknowledge that an infection can occur in other ways than through the genital organs. —*Annales de Gynecologie et d'Obstetrique*, 1892.

THE OVARY IN FIBRO-MYOMA OF THE UTERUS.—Gustav Bulius.—Bulius agrees with Waldeyer and Frommel that no follicles are developed except in foetal life and that any ingrowth of epithelial processes or folds into the stroma of the ovary is a pathological process. He emphasizes the fact that the active ingrowth of epithelium in the stroma of the cortical substance is always associated with severe inflammatory alterations of the stroma itself and especially on the surface of the ovary. The bloodvessels of the ovaries associated fibro-myomas offered the most marked and constant changes among alterations observed. The vascular system showed a typical alteration in the albuginea stroma and follicular apparatus as well. The first stage consisted in a marked arterial hyperæmia and enlargement of the vessels with hypertrophy of the interstitial tissue around the vessel, which is also richer in spindle cells. The mass of the bloodvessels exceeded to quite an extent the amount of interstitial tissue. Together with the above changes there is an alteration in the walls of the vessels. The media is thickened three or four fold. The cells of the intima undergo extensive hypertrophy and the lumen of the vessel is very much contracted or obliterated. This process is most plainly observed in the cortical substance. There is quite constantly a surprising diminution of the primordial follicles which may entirely disappear and this is independent of the age of the patient. Sometimes there is cystic degeneration of the follicles. —*Zeitschrift für Geburtshilfe und Gynäkologie*, Bd., xviii, H. 2, 1892.

THE PREMATURE SEPARATION OF THE PLACENTA AT ITS NORMAL SITE.—M. Grafe.—The writer is of the same opinion as Veit, *i.e.*, that disease of the placenta is of first importance among the causes of placental separation. The great majority of abortions do not depend on the traumatic causes so commonly believed in by the laity and even by some physicians but on decidual alterations which easily cause hæmorrhage. Winter has reported three cases of premature separation of the placenta associated with disease of the kidney. Fehling and Cohn-Carsten have also reported similar cases. The prognosis of separation of the placenta at its normal site is very unfavorable and the mortality is higher than in placenta prævia. —*Zeitschrift für Geburtshilfe und Gynäkologie*, Bd., xxvii, H., 2, 1892.

THE MECHANISM AND THERAPEUTICS OF RUPTURES OF THE UTERUS AND VAGINA.—H. W. Freund.—This essay is a careful and thorough study of the subject and it is a matter of regret that more space cannot be given to it. The critical reader of the literature of this subject cannot fail to observe that the majority of

all cases occur at the close of some obstetrical operation undertaken at a late stage and under dangerous circumstances. The text-books err in recommending rapid delivery and fail to give enough attention to the choice of method. In threatened rupture of the uterus, quick relief by a mutilating operation and only under relatively favorably circumstances should an expert obstetrician adopt any other method of delivery. Particular attention must be given to the attenuated condition and threatened rupture of the cervical segment and no additional strain be placed on it. This explains why both forceps and version are contra-indicated. Most ruptures take place during the extraction of the child as the lower segment of the uterus is drawn upon by the extractive force. Freund recommends a perforator and heavy scissors instead of the blunt hook for the mutilation or decapitation of the child. Instead of the latter operation with the decapitating hook, when the cervical segment is over-distended he practises evisceration and when the thorax and abdominal walls of the child collapse, pressure on the cervix is diminished and the most immediate danger is over. Decapitation can then be performed with greater safety and the child extracted. Delivery must be accomplished under all circumstances when rupture has taken place. Immediate laparotomy is the best method of treating rupture in hospital practice as it gives an opportunity for both indirect and direct treatment of the rupture even when the presenting part has worked through the uterine tissue. Laparotomy is always necessary if the hæmorrhage cannot be arrested by the tampon or other means, also if the intestines are prolapsed and cannot be replaced. Immediate laparotomy gives 58.3 of recoveries; if the operation is delayed for a few hours there is only 47.3 recoveries. —*Zeitschrift für Geburtshilfe und Gynäkologie, Bd., xxiii, Bd., 2, 1892.*

THE SIMULTANEOUS OCCURRENCE OF MYO-FIBROMA AND CANCER OF THE UTERUS.—Ehrendorfer.—The signs of a combination of myo-fibroma and a malignant disease in the interior of the uterus are a persistent bloody watery discharge, very severe menorrhagia with profuse slimy, watery or discolored leucorrhœa in the intervals, in some cases increasing pain, increasing emaciation, rise of evening temperature, roughness of the uterine cavity on examination with the sound and discharge of detritus. He agrees with P. Muller that many cases of myomas do not diminish but continue to grow after the menopause with increasing difficulties for the patients. The climacteric period is the time most susceptible to the appearance of malignant disease. Sarcoma is the most common form, though malignant adenoma is also liable to appear.—*Archiv. für Gynäkologie, Bd., 42, H. 2, 1892.*

THE CONDITION OF THE MUCOUS MEMBRANE IN ATRESIA OF THE GENITALS, AND REMARKS ON TUBAL MENSTRUATION.—Landars and Rheinstein.—In malformations of the genitals, whether atresia or double formation, the mucous membrane throughout the entire tract is in a normal condition. The endometrium in retention of the menstrual fluid perishes as the result of pressure atrophy, but the mucous membrane of the body of the uterus is preserved intact for a remarkable length of time. The mucous membrane of the tube has a high degree of absorptive power in the beginning but this finally disappears under the effect of pressure.

The objective proof that the tube itself menstruates is not yet proven with certainty.—*Archiv. für Gynäkologie, Bd., 42, H. 2, 1892.*

THE EFFECT OF CHLOROFORM ON NORMAL LABOR AS SHOWN BY THE TOKODYNAMOMETER.—Donhoff.—In light narcosis the pressure of uterine contractions is diminished one-half. The strength and frequency of labor-pains are further diminished by deeper and prolonged narcosis. The activity of the uterine contractions increase after narcosis but for some time is less than before the use of chloroform. The action of the abdominal muscles ceases with narcosis. The resistance to the expulsive forces is not materially diminished and the duration of labor is considerably prolonged.—*Archiv. für Gynäkologie, Bd., 42, H. 2, 1892.*

A CASE OF THREE URETERS.—Baumm.—The third ureter opened into the vagina near the urethral orifice, and the continual dribbling of urine was a source of much annoyance to the young woman of eighteen. He performed supra-public cystotomy by a transverse incision, made an opening into the base of the bladder and fixed the ureter in it. The patient recovered with complete continence of urine but later suffered from a hernia at the site of the incision and passed a ligature from the bladder surrounded by sufficient incrustations to form a good sized stone. In another case Baumm would advise operating from the vagina. But two other cases are known in literature.—*Archiv. für Gynäkologie, Bd., 42, H. 2, 1892.*

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

TREATMENT OF VESICULAR KERATITIS.—Drs. Wecker and Landolt think that it is not sufficient in vesicular keratitis, or herpes of the cornea, to evacuate the contents of the vesicles by puncture, inasmuch as the liquid is soon reproduced. The parietes of the vesicles should be removed with forceps, or the lesion should be well scraped with a cataract-knife, and the eye covered with a compress. If the patient will not submit to this operation, they recommend introducing into the eye a pinch of calomel or other powder capable of destroying the thin walls of the vesicles by friction. In addition, instillations of eserine or pilocarpine are useful.—*Therapeutic Gazette*.

ANTISEPTIC SOLUTIONS IN PURULENT MIDDLE-EAR DISEASE.—Dr. Samuel Theobald, of Baltimore, states that a boracic acid solution (fifteen grain), is still, as it has been for some years, his first choice in all cases of recent, and in most cases of chronic otorrhœa. Boracic acid, however, occasionally fails to accomplish what is expected of it, and in exceptional instances aggravates rather than lessens the inflammation. It is in these cases that he has recently used, with very good effect, weak solutions (usually 1 to 8000) of mercuric bichloride. The ear is simply syringed with the solution. Unlike some who have recommended the use of this agent in otorrhœa, he had not usually found it necessary to repeat the syringing more than once in twenty-four hours. He gives notes of several cases in which a prompt arrest of suppuration and closure of the perforation in the tympanic membrane followed the employment of the bichloride solution after boracic acid had been used without effect.—*Medical Record*, August 6, 1892.

EUPHOREN IN THE TREATMENT OF NOSE AND THROAT DISEASES.—Dr. W. F. Chappell highly recommends euphoren in powder in cases of rhinitis fetida. Fifteen cases thus treated seem permanently cured after a month's cessation of treatment. Three of the cases were treated every day for four months. The parts are first cleansed with a half-per-cent solution of creolin and then covered thickly with euphoren from a powder blower. This was done every morning, and at night an ointment of euphoren, drs. ij, vaseline, oz. j, was applied with a brush. It is too soon to say whether the benefit will be permanent, but the prospect seems encouraging. Euphoren is of great value after operations on the throat and nose, on account of its hæmostatic and antiseptic properties.—*International Medical Magazine*, July, 1892.

MASSAGE OF THE SOUND-CONDUCTING APPARATUS OF THE EAR BY MEANS OF VIBRATORY FORCE.—Henry F. Garey, M.D., of Baltimore, Md., explains his method of treating deafness in the *Journal of Ophthalmology, Otology and Laryngology* for July, 1892. If the membrana tympani has been depressed into an abnormal position for some time, on account of the closure of the eustachian tube, changes are necessarily brought about. It loses its elasticity, adhesions take place, the joints of the ossicles become curtailed in their movements, and, as these conditions increase, the hearing power becomes less. It is a well-known fact that such conditions are the hardest to overcome, notwithstanding the restoration of the Eustachian tube to its normal calibre, and there be unimpeded passage from the throat to the middle ear.

The usual modes of treatment are very unsatisfactory in comparison with a method which is directed especially to the parts to be restored, and that is massage. This is a means of treatment which breaks up adhesions, restores the elasticity of the membrana tympani, causes mobility of the ossicles, and finally brings the sound-conducting apparatus of the ear into that condition which is absolutely necessary to hearing. To apply massage is to apply force, and sound is force. In order for the senses to appreciate sound the auditory nerve must receive it in the form of a vibration. If it is necessary for the ear to distinguish sounds only by means of vibrations transmitted to the auditory nerve, then the mere fact that we are hearing a noise or musical tone shows that the sound-conducting apparatus of the ear is in motion, in a healthy ear, performing its normal functions.

It has been found that different pitched tones are suitable to the different cases, and if the aural disease is accompanied by a tinnitus, that tone is selected which, as

far as possible, corresponds in pitch with that produced by the diseased condition. If there is no tinnitus present, a very deep one is selected, followed by others higher, and that one which seems to produce the best immediate effect is used. For these tests each pitch is tried consecutively for five minutes at a time. If there is no immediate improvement with any pitch, a very deep one is used. The loudness is varied according to the deafness of the patient and the intensity of the tinnitus: the length of time is from fifteen to twenty minutes continuously.

Dr. Garey makes a suggestion about testing hearing. It has been noticed by all specialists treating antral diseases that certain pitched sounds are heard better than others by the partially deaf. For instance, a person may not hear the watch pressed against the ear, but ordinary conversation is perfectly audible. On the other hand, the ticking of the watch is heard perfectly well, while the voice is not. If the hearing is not improved for the voice, very little has been accomplished. For this reason Dr. Garey suggests a test whose vibrations correspond to the human voice in its medium range.

Massage by means of vibratory force can be used by the aid of the phonograph, and has already produced some marvellous results. It has been found that the class of cases most benefited have been those in which the pharynx and the mucous membrane leading into the tympanic cavity are in a hypertropic condition: in consequence of which there is partial closure of the eustachian tube. In cases where the mucous membrane is in an atrophied and dry condition, with the eustachian tube easily inflated, the improvement is very slow, and the results not nearly so brilliant as in the former variety; but even in these cases of proliferous catarrh, if there are adhesions of the membrana tympani complicating the case, there is very much improvement in a few treatments in the symptoms produced by those conditions.

Dr. Garey then narrated the history, diagnosis and results in a series of cases treated by vibratory force produced by means of the phonograph. In all cases the hearing was more or less improved; in some the tinnitus relieved entirely, in others, only modified.

HYSTERICAL APHONIA CURED BY COMPRESSION OF THE OVARIES.—Dr. Higuet, of Bruxelles, reports a case of hysterical aphonia cured in about three minutes by slow and progressive compression of the ovaries as recommended by Jonquiére, after several weeks of failure with constitutional treatment, electricity and cold douches. Slight recurrences have taken place at the menstrual periods and under emotional excitement, but they have subsided in a few days without treatment.

Higuet attributes the aphonia to paralysis of the group of inter-arytenoid muscles, and he believes that compression of the ovaries causes spasms of these muscles, and thus overcomes both the paralysis and the aphonia. He states that traction on the ovaries in abdominal surgery frequently produces spasm of the larynx.

ABSOLUTE REST OF THE PARTS THE BEST TREATMENT FOR LESIONS OF THE VOCAL CORDS.—The varied experiences of four years in a well known health resort for lung and throat troubles have convinced Dr. John Traill Green, of Tucson, Arizona Territory, of the truth in the assertion conveyed in the above title. "If any lesions of the vocal cords or adjacent parts of the larynx are discovered, absolute rest of the parts is the best treatment." However, not to the exclusion of other remedies, well known and proved to be potent, but to be insisted upon, no matter what be the medicinal treatment or the climatic surroundings. Some patients, and, indeed, some prominent physicians, have an idea that what is called "whispering" does not irritate the cords and may be allowed. If one watches a patient closely he will soon see that the so-called whispering (especially when trying to make the sound carry some distance) is even more of a strain than using the voice in its natural tones. Again, if we examine the larynx after the patient has over-exerted the cords by the so-called social or domestic duties that invalids insist must be carried out, we are sure to find any ulcers irritated, any congestion worse, and patients themselves can easily feel the increased pain.

The greatest difficulties attend the thorough carrying out of this complete rest of the vocal cords, Dr. Green succeeding in only one case, but with results which put the others to shame for the lack of will power to stop talking. This case was a physician in active practice, who carried on his professional work by means of slate and pencil.—*Medical Record*, July 9, 1892.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,

FRANK H. PRITCHARD, M.D., AND E. M. HOWARD, M.D.

INTOXICATION BY URANIUM AND ITS SALTS.—The different salts of uranium produce nearly the same symptoms. One of the first symptoms produced in poisoning of animals is torpor, as if the nervous centres were immediately affected, and twenty-five minutes after the first hypodermic injection of the nitrate of uranium a small amount of sugar and albumin can be detected in the urine of dogs and rabbits. Twenty-four hours after, the animals are materially affected (the urine containing 0.2 per cent. of albumin and 1.5 per cent. of sugar). This condition is accompanied by polyuria during the first stages of intoxication, but the quantity of urine rapidly diminishes and finally ends in anuria. The urinary sediment contains hyaline and granular casts and epithelial cells. The author has never been able to prove the assertion of Chittenden that there is oxaluria; on the other hand, there are numerous phosphates (the phosphates of ammonium and magnesium, phosphates of lime, and a notable increase of phosphoric acid), a decrease of urea and chlorides, and the presence of acetone. The renal congestion is so great that many hæmorrhages are found under the capsule, occasionally in the glomeruli, and by far the most important lesion, necrosis of the convoluted tubules.

In the case of glycosuria we find the liver congested as well as the kidneys; in extreme cases, with necrosis of the hepatic cells, characterized by fatty and especially by hyaline globules which split up the cell, virtually a death process.

In the alimentary canal, there is a speedy loss of appetite, a little thirst at the beginning, and soon complete anorexia; sometimes, vomiting, and finally diarrhoea or constipation. The autopsy proves the existence of violent gastro-enteritis with generalized ecchymoses. Edward Blake called attention to the frequency of ulceration of the stomach, and classed uranium among the remedies homœopathic to round ulcers.

Uranium nitrate does indeed produce generalized ecchymoses, not only in the alimentary canal, but also in the heart, pericardium, kidneys, etc.

In the intoxication of uranium nitrate, nervous phenomena predominate; the general torpor is accompanied by a paretic condition amounting, sometimes, almost to paralysis, with lowered temperature, diminished respiration, and a lessened expiration of carbonic acid gas.

Woroschilsky, experimenting with a double salt of uranium, has shown that under the influence of this poison a slowing-up of the functions of the tissues takes place; under the microscope, it is precisely as he stated; cessation of the motion of the cilia of the respiratory epithelium, cessation of muscular contraction by the electric current, paralysis of the motor nerves, dilatation of the bloodvessels. Finally, uranium acts on the blood by lessening the exchange of oxygen, and in slackening the reduction of oxy-hæmoglobin.—Dr. Francis Cartier in the *North American Journal of Homœopathy*, August, 1892.

AURAL THERAPEUTICS.—*Picric Acid*.—External ear. This drug is indicated in furuncular and circumscribed inflamed meatus, and, in the chronic or subacute forms, it has delighted patients and surgeons. In debilitated cases, with redness and localized tenderness of the meatus, it acts like magic.

Calcarea Picrata.—Extreme physical debility. In circumscribed inflammation of the canal it is almost a specific, and in diffuse inflammation (if the infiltration is not as marked as when *hepar* is used) it is an admirable remedy. The general prostration is a collateral symptom worthy of note.

Baryta Mur.—Confirmation is given of the inference that it has an effect upon the muscular action of the pharynx, Eustachian tube, and tensor tympani. Where action is to open and close the Eustachian tube, repeatedly curative.

Capsicum.—Chronic suppuration in adults especially. The typical cases of cures are those in which acute symptoms occur in chronic cases. The mastoid cells become involved; painful swelling behind the ear.

Cinchona Officinalis.—Hæmorrhage from ear; indolent ulceration, with passive hæmorrhage. Remark is made of the danger to the ear from abuse of quinia, and the statement made that the cases of subjective sounds occurring in the person of patients who have been affected by quinine are almost hopeless. No antidote has been found for cinchona in middle ear diseases.

Psorinum.—This remedy merits all the commendation which it has received. In chronic suppurative inflammation of the middle ear, with a discharge of unhealthy, watery, fetid pus, with vesicular eruption about the meatus or extending upon the cheeks, associated with scabby ulcers behind the ears, or on the vertex, with excessive itching, so that children rub and dig at their ears beyond control. It is good practice to use it as an intercurrent with other constitutional remedies. A single dose at long intervals.

Tellurium.—Acute or chronic suppuration of the middle ear, with a vesicular condition of the tissues of the canal and drum-head, the exudation being a watery fluid mixed with pus, smelling like fish-pickle, and excoriates the skin. It is suggested that its initiation is in the form of a phlyctenular eruption.

Ferrum Phos.—Fulness and throbbing of head; rise of temperature; hyperæmia of the periphery of the drum-head and of the manubrial plexus very marked, indicated up to the point of serous exudation into the tissues, and perhaps longer for high temperature; rapid, full pulse. Uses it as a routine remedy for out-door patients, and as a prophylactic in cases of earache of children that cannot be seen. The characteristic subjective symptom is the pulsation. Objective symptom is hyperæmia of drum-head.

Kali Muriatum.—Closure of Eustachian tube as the result of naso-pharyngeal catarrh. Objective symptoms are those of a hypertrophous naso-pharyngeal tract, with excessive secretion, which is white, sticky, clear mucus, rather stringy. If discharges are yellow and rather more lumpy in suppurative otitis, kali sulph. is the remedy.

Chenopodium.—Deafness to the sound of the voice, but exquisite sensitiveness to the sound of passing carriages. (Staggering like a drunken man when walking, with nausea and vertigo, as given in Allen's *Encyclopædia*, suggest a lesion of otitis interna exudative serosa.) Sensitiveness to deep tones has led to the successful use of this drug.

Causticum.—Re-echoing of one's own words and steps (repeatedly confirmed as a characteristic); voice seems to come out of ears, not mouth; sounds as if person were speaking in a great cavern or vault.—Dr. H. C. Houghton in the *Jour. of Ophthalm., Otol. and Laryngology*, July, 1892.

BARYTA CARB. IN NOCTURNAL EMISSIONS.—Dr. Percy Wilde reports the case of a young man with decided intellectual abilities, of good moral tone, who consulted him, and who presented a typical instance of the sufferer from nocturnal emissions and the disorders which accompany it. The pulse was quick and easily compressible, the heart was working with misdirected energy, and its sounds could be heard all over the chest. He suffered much from distressing palpitation and also from the form of indigestion which arises from want of nerve power in the stomach and intestines. The food caused flatulent distension of the abdomen and was slow in digesting. He had a feeling of weariness with constant inclination to lie or sit down. These symptoms were always worse after an emission, and the capacity for study was so diminished that he despaired of being able to enter the profession he was studying. Cactus decidedly diminished the heart symptoms; hyoseyamus had very little effect in checking the emissions. Searching the materia medica for a more deeply action remedy, *baryta carb.* was selected. It has the (1) Emissions followed by exhaustion. (2) The frequent and too abundant flow of colorless urine which commonly accompanies hysteria and nervous exhaustion. (3) Violent beating and palpitation of the heart. (4) Dull aching in the back relieved by lying down. (5) Physical, nervous and mental weakness. (6) The digestive troubles which accompany nervous debility. Under the use of this remedy, all symptoms disappeared, and the patient was cured.—*Monthly Homœopathic Review*, June, 1892.

CEDRON IN NEURALGIA.—Dr. A. Spiers Alexander reports a second verification of the action of cedron in malarial neuralgia. Remarking on the case, the author quotes the symptoms from Hering's *Guiding Symptoms* the symptoms which may serve as reliable indications for the administration of cedron in neuralgia:

Time.—7 or 8 P.M. Chronic intermittent prosopalgia.

Fever.—Miasmatic fevers of low marshy regions in warm seasons and tropical countries; chill returns with clock-like regularity.

Attacks, periodicity.—Attacks occur with unerring periodicity to the hour.

Locality and direction.—Left eye, a tie-like pain; shooting pain over left eye.

The three leading characteristics then are: Orbital or supraorbital pain; clock-like regularity of recurrence and malarial origin.—*Monthly Homœopathic Review*, June, 1892.

KALI BROMATUM IN ACNEIFORM ERUPTION.—Married woman, æt. thirty-six. Poorly nourished, weak, despondent. Acnoid eruption of face of six months' standing. *Pathogenetic Symptoms*: Dark red papules and yellow-tipped pustules isolated, soon disappearing, leaving stain of skin. Mental depression. Muscular weakness. *Remarks*: Drug given in trituration, three times a day. The indication on which the drug was prescribed was the resemblance of the general condition to the cachexia induced by large doses. Cure was effected in eight weeks.—Dr. H. M. Dearborn in the *North Amer. Jour. of Homœopathy*, June, 1892.

MENTAL SYMPTOMS IN A CASE OF LEAD POISONING.—Dr. Mayer records the case of a young man, 20 years of age, who for six years had worked in a type-foundry and who six times had suffered from lead colic. He seemed to be profoundly affected by lead, and suffered from headache, constipation, paralysis of the right radial nerve. One day he had a typical attack of epilepsy which suddenly set in with loss of consciousness and speech. From this moment the headache continued to increase, and for several days he had attacks of vomiting. At the thirteenth day, after the last evacuation of the bowels, he commenced to be delirious, saw spider webs everywhere, felt balls and strings of lead in his hand and hairy worms in his body. After fourteen days the psychosis had disappeared and nothing remained but a form of exhaustion with amnesia. He complained of a feeling of constriction in the toes and presented a bilateral paralysis of the abductors.—*L'Art Medical*, June, 1892.

THE ACTION OF SYZYGIUM IN A CASE OF DIABETES.—Male, æt. seventy-two; married; a physician had diabetes mellitus for about four years; passing from 600 to 1000 grains of sugar a day; he suffered from emaciation, weakness, thirst and itching. He had been taking for several days a five-grain powder of *syzygium* *iv. trit.* four times a day. While out on his rounds, after disregarding a slight intimation to stool (twenty minutes previous), he had with sudden urgency a large involuntary stool, painless, brown, semi-fluid, almost inodorous, and followed by sense of relief. In three-quarters of an hour another stool, not quite so urgent and less fluid. The same experience ensued two or three weeks later on taking the drug in the same way. No relapse, during six or eight months, although he occasionally taken a three-grain dose at intervals of twenty-four or forty-eight hours.—Dr. R. C. Moffat in the *North American Journal of Homœopathy* June, 1892.

CONIUM IN UTERINE FIBROID.—Female, æt. forty-five had enlarged abdomen from fibroid tumor of six years' duration, pronounced by the late Dr. Hunter not suited for removal. For six months she suffered also from sharp pains in breasts. *Pathogenetic Symptoms*: Sharp, stinging pains in breasts, worse at night. Areas of sensitiveness to pressure in breasts giving a feeling of firmness or induration to touch. *Clinical Symptoms*: Feeling of induration, and sensitiveness especially in outer part of breasts. Swelling of abdomen. *Remarks*: Under treatment, size of abdomen decreased with lessening of pressure symptoms. Pains were cured in three weeks, but recurred and were again relieved. Apparent thickening of tissue of breasts disappeared in ten weeks. Conium 1x in dilution was given twice daily. Under its occasional use patient has continued very comfortable for last three years.—Dr. H. M. Dearborn in the *North Amer. Journ. of Hom.*, June, 1892.

TREATMENT OF GOUT.—Dr. Theodor Kafka, of Carlsbad, Austria, advises in the treatment of gout a dietary resembling that of a diabetic; green vegetables and fruit are to be recommended and prescribed. But a small quantity of saccharine food stuffs and a relatively small quantity of carbohydrates are to be allowed, though they may be forbidden entirely. A little meat may be permitted, and above all poultry. Fatty fishes are forbidden, a number of sea fish, veal and very young mutton. Game, beef and pork may be allowed in small quantities, but an excess is to be avoided. A great amount of exercise and care of the skin, with baths are of service. The alkalies and the alkaline waters are of use in this disease. Carlsbad stands at the head, with Vichy, Wiesbaden, Kissingen, etc., to follow. Artificial or natural lithiated waters as well as piperizin are the chief agents of the old school, in the treatment of the disease.

Homœopathic Treatment of the Attack.—*Aconite*.—If inflammation of one or more joints is distinctly to be seen, then give *aconite* 3x. In case that the pains are violent repeat the remedy every quarter of an hour.

Bryonia.—If the violence of the pains and fever decrease, *bryonia* may be administered, every one to two hours, until the local phenomena have disappeared.

Belladonna.—When the pains are very severe and a certain nervous irritability is present then *belladonna* may be substituted for *aconite*. *Apis* may also be indicated here.

Colchicum.—This drug often acts better than *aconite*, when the pains are severe and there is great painfulness.

Arnica.—This drug has also given good results.

If the disease is slow in retrograding then one may employ *kali hydroiodicum*, in a saturated solution, or at least, in an alcoholic solution. The initial dose may be placed at 2-3 drops two or three times a day, increasing the quantity every third day, while the same drug is used externally in the form of a salve: iodide of potash, 8 grs., lard or vaseline, 5 drachms. Rub this into the joint and administer this iodine internally until a complete cure is obtained. The writer has found this procedure of great value in the treatment of chronic cases. *Mercurius solubilis* has been found by him to be an excellent remedy in the chronic form. If the results are still unsatisfactory then one may administer one dose of sulphur, 6x-30x, per diem, in order to stimulate the delayed resorption. Farrington also recommends ammonium phosphoricum, antimonium crudum, acidum benzoicum, berberis vulgaris, calcarea carbonica, colocynthis, guaiacum, lithium carbonicum, lycopodium, pulsatilla, a remedy which the writer uses in alternation with *bryonia*, and *staphysagria*. *Ledum pal.* is also a remedy of value.—*Allgemeine Homœopathische Zeitung*, Nos. 25 and 26, 1892.

VERBASCUM THAPSUS.—A correspondent of the *Homœopathische Monatsblätter*, No. 7, 1892, calls attention to the remedial value of mullein oil, obtained by pouring olive oil over the buds of the plant and allowing it to macerate for eight days, as an anodyne in painful hæmorrhoids. Bleeding piles are also favorably influenced by the external application of the oil. The oil is applied two or three times a day. It is also given internally. The tincture may be given in doses of 8 drops, three times a day. A characteristic symptom is a coated tongue, the coat being of the appearance as if coffee had been strewn over the tongue and especially at the base.

SEPIA IN VERTIGO.—Dr. Dahlke, of Berlin, reports the case of a man, 40 years of age, who complained of periodic attacks of vertigo, which were sometimes accompanied by vomiting. This was associated with a sensation of stupid fulness in the head and great corporeal exhaustion. *Gelseminum* was given without any results. A second examination revealed that the vertiginous attacks came on in the open air and on lying down, especially when the pillow is too low. For this reason he lies with his head high at night. One dose of *sepia* 9x, was given with immediate improvement. The symptom, vertigo on walking in the open air is known as characteristic of *sepia*, but the symptom, vertigo on lying down is not recorded, to the knowledge of the writer. The ninety-ninth symptom of Hahnemann's proving reads: confused vertigo every afternoon from 4-6 on sitting or walking. *Apis* has vertigo worse during sitting, exceedingly pronounced on lying and closing the eyes. *Lachesis* has vertigo worse on sitting and vertigo on sitting down. It has cured vertigo on closing the eyes and after lying down (Hering). Farrington claims *theridion* and *moschus* to have the same symptoms. *Mephitis* has vertigo on sitting.—*Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, Bd. xi, Hft. iii.

THE TASTE-SYMPTOMS OF IODOFORM.—Dr. Dahlke, of Berlin, was consulted by a young girl who had been given iodoform in pill form, by an allopathic physician, on account of a large group of enlarged cervical glands. After taking them, the following symptoms set in: Continually hungry; she eats much and often; she craves fat and unsalted foods, the latter on account of a continual salty taste in her mouth; muscular pains over the whole body, being especially pronounced in the chest muscles; great exhaustion; sleep restless; no distinct emaciation. The writer thinks this group of symptoms to be of value, as the bulmia and salty taste in the mouth are both characteristic of iodine. He regards the majority of the taste-symptoms of our materia medica to be due to the local action of the remedy. Yet there are certain ones which are not of local origin. A bitter taste has been observed after injections of morphine; also after poisoning by santonine. *Natrum sulphuricum* is characterized by a bitter taste. The author was consulted by a woman who, besides a bitter taste in the mouth, did not complain of anything else abnormal. She received *natrum sulphuricum* 4x, three drops per diem. The bitter taste disappeared after a few days, but she complained that as long as she took the drops she suffered from an early-in-the-morning diarrhoea, with rumbling in the bowels. Those remedies which have a bloody taste in the mouth are those which produce venous stasis.—*Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, Bd. xi., Hft. iii.

AURUM IN SUICIDAL MELANCHOLIA.—Dr. H. Goullon records the case of a woman, 55 years of age, whose periods had ceased for fifteen years. She has had six children, and is not sensually inclined. She was well nourished and not addicted to alcoholic drinks. Her family life had always been pleasant. She went to attend a daughter during a confinement, and while staying there she was seized with homesickness. This was followed by other symptoms of mental alienation. She was excitable, reproached her surroundings, was melancholic and jealous. She attended to her house-work as though she was distracted and absent-minded, finding no pleasure in her work. At night she would see lights in her room, and assert that she heard the carpet creak. Her sleep was restless; she was sexually excitable and jealous of her husband, accusing him of associating with other women, and without cause. She suffered from a rush of blood to the head, having always frontal headache and a staring look. Her face was swollen, red, hot, while her extremities were cold. Once she had a congestive rush of blood to the head and chest, accompanied by cough, when she vomited bright red blood and talked wildly. That whole day she was out of her senses, wanted to go away, and her mind was filled with suicidal thoughts. She laughed and cried; laughed at nothing. At night she dreamed terrible dreams of murder and death. Her stools were hard and knotty. Aurum 5x was given, one powder every evening. Eight days after the husband reported that his wife was much improved. Already on the third day she became sensible and said that she had offended her husband. Her hallucinations disappeared, her bowels became regular, and she slept better, while on the whole she became greatly improved.—*Allgemeine Homœopathische Zeitung*, Nos. 25 and 26, 1892.

DR. MACFARLAN'S PROVINGS AND CLINICAL OBSERVATIONS WITH HIGH POTENCIES.—*China-off.* 87m.—Exceedingly nervous and sensitive, pains generally all over; frequently verified the symptom of over-sensitiveness to pain or noises.

Cichorium-intybus. 5c.—Neuralgia down the side of the neck, right side mostly.

Cimicifuga-rac. 95m.—Medicine given for three weeks every two hours caused pains all through her lower limbs, something of the character of growing pains in young persons, only a great deal worse; complete loss of appetite, *backache*, in small of back; fever every afternoon between twelve and four; menses (usually very regular) delayed three weeks, coughs at night, sleeps badly, *legs mostly affected*; heaviness in lower extremities.

Clematis-virg. 5c.—Have given this often with success in orchitis.

Coffea-cruda. 70m.—Quickly cured a case of violent hysterical convulsions in a young girl. The disease had been of long standing. Patient had been confined to room and bed for some weeks. No other remedy given.

Collinsonia-can. 45m.—Distress in the epigastrium; feeling of weight and pressure, with flatulency; disposition to piles.

Chloral-hydrat. cm.—Caused constant urination, attended with pain and scalding sensation; nervous, irritable and restless.

Uinum Mercatum^{3m}.—Troublesome, teasing cough, no expectoration.

Camphor^{30m}.—Promptly helped many times the watery diarrhœa of children, sudden nausea, with severe profuse vomiting; inferior to creosote in cholera infantum.

Cornus-Florida^{45m}.—Neuralgic sharp pains began on right elbow, extending to the hand and shoulder, passing down the right side and then up the left; pain settled about the heart, causing feeling of pressure and palpitation; couldn't use the arm because of pain and lameness, hands and feet appeared swollen, and the pains were of a darting, needle-like kind, very severe; difficulty of passing water, no force to it. Left eye very weak, waters readily, vision appears slightly obscured, elbows and wrist pain her, aching at the waist, as if she would break in two, to use her own language; *sighs very of en*, gagged as if she would vomit; frequently in the morning chilly sensations come on, although she does not wish to be covered; pains run up the whole left side of the trunk, or body, like lightning, seems as if it would give her a twist or jerk while coming on. *Sweat* just rolls down from her, chilly, warm sensation, alternating with cramps from the sides of her waist running towards the pubes, sleepy but could scarcely sleep, all night. Had to get up and look out of the window at night, she was so sleepless; couldn't sleep in the day-time, continual slight perspiration.

Cresotum^{cm}. (*Beechwood*).—Produces an isolated pimply rash on the face in many provers. I have made remarkable cures in both sexes of chronic periodical headaches in frontal region, piercing pain, where welts or swellings would come on the scalp after the suffering existed some time; not useful in congestive headaches. Small red papules about the lower part of the face and neck; remarkably curative in ailments of teething, particularly in hot weather; vomiting and frequent green stools.

Cuprum-acet^{45m}.—Cramp in stomach, but mostly low down toward the inguinal region, as if the parts would open, or, as if she would be torn apart. Slight headache in the temples, worse at junction of *occipital with both parietal bones*; aching pain in head, and scalp sore to touch; feels as if she had a load through the *apex of both lungs*. Inner side of knees feel sore, and ankles hurt her, tongue coated with thick fur. Very disagreeable taste, bowels rather costive, which were loose; somewhat sleepless; aching and soreness down the *outside of the left thigh and leg* from the hip to the foot, right not much affected. Sharp pains, with soreness to touch on both malar bones. *Throat very sore*, hurts her severely, tries to raise phlegm but gets up little, taste is like something putrid, singular feeling all over her, don't last long, can't explain it, feels as if she is moving without making any personal effort. Feels as if *her back at the top of her sacrum would break*, severe pain and cramp in abdomen. She is always worse in afternoon and evening and better in forenoon.

Cuprum-met^{3m}.—Male prover. *Backache* at the top of sacrum, severe griping and spasm about the region of the heart, head troubles him with a confused feeling.

Cactus-grand^{cm}.—Feeling about the heart as if it were compressed, anxiety, sighing, breathing, short breathing on the least exertion.

Cobalt-chloride^{cm}.—Tingling sensations in the feet as if asleep, sometimes like pricking of needles; circulation imperfect.

Causticum^{30m}.—Profuse ropy, clear discharge from vagina, pain in her left hip-joint, commenced in an instant, as if her hip was suddenly hurt, soreness to touch on the front of the forearms, but lower extremities mostly affected; symptoms of a bad cold, coughed much, then a constant sniffling discharge from the nose, eyes water a good deal, light and heat of the fire hurt her eyes, feels sometimes as if there was excessive heat in her forehead. *Coughed so much* she thinks it affected her bowels, made them sore, cough strains her whole body. Cured a large syphilitic (?) ulcer on scrotum, throat became sore, appetite diminished. Complained of constant coldness, and had shivering sensations while taking the remedy. Severe pain at each parietal protuberance, with repetition of general symptoms mentioned in paragraph above. Given to a prover, relieved obstinate constipation, bowels now move more regularly and almost daily.

Cimic-fuga-rac^{95m}.—Relieved pains in abdomen, uterus and distress about the heart, also severe bearing-down sensation, occurring in a pregnant woman who had been suffering a long time.

Cinchona^{76m}.—Caused watery diarrhœa, with griping on fourth day, and lasted three days; acute pain from right shoulder to elbow, extremity quite lame. Slight urethritis in the male. Lacks sufficient confirmation to be sure of this.



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CHOLERA ASIATICA.

BY EDUARDO FORNIAS, M.D., PHILADELPHIA.

DEFINITION.—A general, epidemic, specific disease of rapid course and great mortality, with special lesions in the small intestine and more or less destruction of the blood-life. Its clinical syndrome could not be more striking: Forcible ejection of watery liquid from the alimentary canal, arrest of secretions, shrinking of the tissues, capillary stasis, incomplete hæmotosis, cyanosis, algidity, collapse, and superficial epithelial desquamation of the mucous membrane of the small intestine, which constitutes the characteristic alvine flux of the disease.

ORIGIN AND ÆTIOLOGY.—Probably after remaining for a long time confined in India, its birth-place, this mortal disease made for the first time an explosion at Jessore in 1817, and invaded other Asiatic regions. After this first migratory epidemic, Europe has been occasionally visited by the terrible scourge. The appearance of the three great epidemics, that of 1830 and 1846 by land, and that of 1865 by sea, will always keep a prominent place in the history of cholera. Our continent was first invaded on the 8th of June, 1832, at Quebec, and in the same month attacked Montreal, Albany and New York. Philadelphia had its first cases in July, Boston and Baltimore were moderately affected in August, and it extended as far as New Orleans. It had entered twelve different States before

September. It again visited this country in 1847 to 1849. Philadelphia and New York in the month of May. From 1850 to 1854, cholera lingered in various places of Europe and America, almost sporadically. 1854 was the year of the peculiar epidemic at Columbia, Lancaster Co., Pennsylvania, so remarkable for the absence of some of the usual promotive conditions of cholera (Hartshorne). The last visitations of any account were in 1866 and 1873. So we find, that *endemic* in India, where it seems to be nursed and favored by special telluric conditions and the infection of the waters, it becomes *epidemic* under the influence of crowding and defective hygiene, as it has been often observed during great pilgrimages. Pilgrims on leaving the endemic area have carried with them the germ of the disease, which has spread, following the great human currents and especially the routes of traffic, both by land and sea. It has always progressed by making temporary halts, thus indicating the places we should shun and where means of protection should be established, but its halting-places seem to be always those which present certain local condition of atmosphere and soil. It is *contagious*, the vehicle of the poison being the dejections of those suffering from the disease, which soil the linen and bed-clothes, or are poured into cesspools, thus contaminating the waters. Probably the cadaver and merchandises can convey it, *but it is not communicable directly from man to man*. Air and drinking-water are its agents of propagation, but certain conditions, such as low and damp localities, hot weather, destitution, filth and excess, undoubtedly favor its development. The pathogenic agent seems to be the *comma bacillus*.

BACTERIOLOGY.—The epidemic of cholera which raged in Egypt and part of Europe in 1884, gave ample opportunity to search for the infectious agent of the disease. It has been asserted that Koch has constantly found in the contents of the small intestine, as well as in its walls, a little curved microbe, which on account of its shape has been called *comma bacillus*. Other foreign observers have also found it in large quantities, especially in the rice-water stools, and Drs. Macleod and Milles, of England, have shown that the microbes found by Lewis in the fluid of the mouth of healthy persons, and by Denike in old cheese, etc., are entirely different from Koch's bacillus. "Koch maintains (says Griffiths, of London), that he has reproduced the disease, but his experiments are not as yet regarded in this country as sufficiently conclusive." The researches of Klein and of the British Investigation Committee sent recently to Spain, have likewise shown that Koch's conclusions are premature, and that

the bacillus of cholera has not yet been isolated. But Dieulafoy, of Paris, states, that he not only succeeded in isolating and cultivating this microbe, but that by injecting it into various animals, after the contents of the stomach were rendered alkaline, he obtained choleric-form symptoms.

In spite of this controversy we are taught, and I think we should know, that the *cholera bacillus* can be easily cultivated in milk, neutral bouillon, nutrient gelatine, slightly alkaline or neutral, agar-agar and on boiled potatoes at 16° to 40° C. At a temperature of 30° to 40° C., it acquires its maximum of vitality, but it has been ascertained that it is still alive at 10° C., a fact which explains the propagation of cholera at any season of the year. Its habitat is the intestinal canal, where it multiplies with an enormous rapidity, but it is in the alvine liquid of the small intestines and when the cases are fulminant or very rapid that we principally meet with it; when the disease lasts longer, when the patient dies in the algid stage, this bacillus is found then associated to other micro-organisms, which render its search more difficult, and the longer the disease lasts the greater the number of these intruders. The *comma bacillus* disappears entirely during the stage of reaction. It is not found in any other part of the body, but in the intestines, first floating in the alvine liquid, later penetrating the mucous membrane after shedding of the epithelium. It becomes formidable by the poison which it eliminates as it grows. The *ptomaines* produced by this microbe are various, and they are the poisons which provoke the diarrhœa, the coagulation of the blood, the contractions, the alidity, etc. In the presence of moisture it may remain alive outside of the body for long periods and may even multiply, and so the disease may be conveyed in bundles of infected clothing, in the drinking water and on the moist surfaces of vegetables and fruits (Prudden). The odor emitted by the comma-bacillus is noticeable in the breath of those suffering from cholera and in the artificial culture of the microbe. In the culture it produces substances which, under the influence of diluted sulphuric acid, take the coloration of the blue and red dyes (Brieger, Heidelberg Congress, September, 1889). The comma bacillus of Koch is readily stained by the following methods. 1. The fluid containing the microbe is spread and dried on a cover-glass; then stained with an aqueous solution of fuchsine, washed with water, dried, and mounted in Canada balsam. 2. The hardened sections of the intestines are placed in a strong aqueous solution of methylene-blue for twenty-four hours, and finally treated in the usual way (Griffiths).

SYMPTOMS AND COURSE.—1. *Prodromic stage*: The first symptom of prominence is the so-called *premonitory diarrhœa*; the stools are first fecal, then serous and bilious, with *borborygmi* and *epigastric sinking*, without colics or tenesmus, with or without loss of appetite and forces. But the attack may come on without any warning, and the patient becomes suddenly affected by symptoms characteristic of the second stage without premonitory stools, or rapidly passes into the stage of collapse without vomiting or purging, death occurring within a few hours. 2. *Stage of progression*: The stools soon cease to be bile-stained, become more frequent and copious, inodorous, perfectly liquid, colorless or opalescent, and contain bacilli and floating flocculi, leaving on standing a sediment resembling flakes of boiled rice, with a whey-like fluid above (rice-water stools). This is no more diarrhœa, but a sort of intestinal flux. The evacuation of this liquid is usually painless, attended by *borborygmi*, seldom by griping, often by a sense of relief. Vomiting follows shortly and becomes also a prominent symptom, the contents of the stomach being first rejected, and then all the water which the patient eagerly takes to allay his violent thirst, which an intense heat in the epigastrium makes still more distressing. The first vomited matter is bile-stained, but soon assumes a colorless serous appearance very much like that of the fluid expelled by the bowels. Painful cramps usually set in with the alvine evacuations, and affect chiefly the fingers and toes, calves of legs and thighs, and sometimes the muscles of the abdomen. By this time, notwithstanding a marked coldness of the skin and extremities, the internal temperature is all the while rising, the rectum and vagina registering 103° F. or more. This stage merges so rapidly into the algid that it can be well considered a part of it. 3. **STAGE OF COLLAPSE OR ALGID**: The alimentary canal may still keep on ejecting enormous quantities of the characteristic fluid, or the vomiting and purging cease or are greatly diminished, sometimes attended by retching, or followed by a troublesome hiccough. Signs of prostration, waste of tissue and incomplete hæmotosis become now very prominent, and if a vein be opened then only a few drops of a dark, viscid, tarry blood escapes. The urinary and biliary secretions are totally suppressed. All the soft tissues of the body shrink, the hands become sodden like those of a washerwoman, the nails blue; the skin is more or less livid, bathed in cold, clammy sweats, inelastic, and when pinched up, the folds made, persist. The features are pinched, the eyeballs sunken, the cornea flattened, the cheeks hollow, and a leaden or livid hue surrounds the eyes

and lips (*facies choleraica*). The voice is reduced to a mere whispering, almost inaudible (*vox choleraica*). The temperature, 8 to 10° C. lower at the mouth, hands and feet; raised at the central parts. The pulse is very small, becomes less and less perceptible at the wrist, and may disappear even from the brachial and carotid arteries. The first sound of the heart may not be heard; respiration is very shallow and hurried, the expired air is cold, and sometimes there is paroxysmal dyspnoea. The patient, who from the outset is very anxious, restless and wakeful, soon becomes apathetic and indifferent, and only complains of thirst, heat at the epigastrium, and of cramps, if these still persist. The mind is usually clear, but in fatal cases stupor sets in, followed by coma. Other nervous phenomena occasionally attending the algid stage are: headache, vertigo, tinnitus aurium, and impaired sight and hearing. This period, which in some cases hardly lasts two or three hours, never exceeds thirty hours. The greater part of its symptoms are undoubtedly due to the inspissated condition of the blood, after having been robbed of its watery elements by the incessant losses through vomiting and purging; but others, whose views have received confirmation by the discovery of ptomaines produced by the comma bacillus, believe that a chemical poison enters the blood, produces spasm of the arterioles, and so leads to local and general asphyxia (Dawson Williams).

4. STAGE OF REACTION: If death do not occur in from twenty-four to forty-eight hours, the signs of reaction appear, and recovery may be rapid. This is of special frequency in the Tropics, where reaction may be so little marked that the patient passes at once into convalescence by the mere cessation of symptoms and the reappearance of urine. Signs of amendment are: change of expression and color of the face; improvement of the pulse, heart's action and respiration; re-establishment of the functions of sanguification, calorification and secretion, with abatement of the other symptoms. Frequently, however, the reaction is only transient or imperfect, and the occurrence of great cerebral and pulmonary congestion endangers the life of the patient, or he subsequently dies poisoned by his own secretions (*uræmia*), in which case death is preceded by headache, drowsiness, vomiting, convulsions, and coma; at other times the reaction may proceed to considerable fever and the typhoid state supervenes, from which the sufferer only recovers very slowly, if at all. The above are the most frequent complications of cholera, but convalescence is occasionally delayed by subcutaneous abscesses, parotid suppuration, sloughing of the cornea, and by dyspeptic and paralytic troubles.

RARE FORMS.—The description of the disease given above embraces the *ordinary, typical forms*, as well as those *mild ones* which have been called *cholerine*, and are characterized by the premonitory diarrhœa with only some cramps and vomiting. Between these mild and severe forms, however, there are *intermediate ones* of variable course and termination. But there are two *rare forms* which deserve a passing notice: 1. The *true fulminant form* of India, in which the patient, apparently overwhelmed by the poison, falls down and dies within one or two hours without vomiting and purging. 2. Those cases called *cholera sicca*, in which, due to intestinal paralysis, the alvine exudation cannot be expelled, and is found in the bowels after death.

DIAGNOSIS.—Error can only occur in sporadic cases. Outside of its epidemic character, high mortality, and copious alvine evacuations, it differs from *cholera morbus* in that it is specific, and due to an infectious agent. *Cholera morbus* occurs in summer and fall, from errors of diet, and the stools never contain floating flocculi and epithelial débris; the vomited matter consists partly of the food taken, and partly of slimy mucus. There is no marked coldness, pinched look, sepulchral voice, and imperceptible pulse. The reaction that follows the algid stage of *true cholera* is never observed in *cholera morbus*, where the whole trouble ceases with the stool.

Choleriform diarrhœa and *cholerine* are attenuated forms of *Asiatic cholera*, which they can transmit or be transmitted by it. The *choleric form of pernicious fever* is very difficult to differentiate from *true cholera* in countries where both diseases prevail simultaneously, as in Cochin-China. In such cases, the presence of melanic pigment in the blood is our principal element of decision. Cases of *collapse* from rupture of the stomach or intestine, and cases of internal strangulation, have been mistaken for cholera during its prevalence. *Arsenical poisoning*, during cholera epidemics, must not be mistaken for cholera. Insurance on the lives of persons intentionally poisoned by arsenic have been paid by the companies on the good faith of the attending physician. *Acute poisoning by corrosive sublimate* presents also some analogy with cholera; but the effect of these two drugs on the mouth and lips is very marked; the vomiting is always painful, and precedes the diarrhœa, and the stools are not so copious, or contain flakes resembling boiled rice. The *poisoning by the tartrate of antimony* bears such a great resemblance to cholera that it has been described by various authors under the name of *cholera stibiatum*. The effect of *croton oil* should also be borne in mind.

PROGNOSIS.—If we take as a guide old-school averages of mortality, the prognosis is, of course, very grave; but, our reports from honest and conscientious men is more encouraging. Cholera is more fatal in children, old people, and weakly persons, than in robust adults. A great proportion of those suffering from *alcoholism* fall easy victims of the disease. The early onset of *collapse* or *profound collapse with relaxation of the sphincters*, are very unfavorable signs. A *tendency to fall back into algidity* at the moment of reaction, is also adverse. Of very serious import is, likewise, *cardiac failure*, especially the *disappearance of the radial pulse*. During the early part of reaction, *continued suppression of urine*, *high temperature*, *bloody stools*, and *pulmonary complications* are unpropitious signs, and no less portentous are *coma*, *delirium*, and *convulsions*.

PATHOLOGICAL ANATOMY.—The most distinctive *post-mortem appearances* are an *extreme rigidity* (rigor mortis), which may cause curious movements and alarm the ignorant, and a *cyanotic hue*, as well marked as that present at the last hours of life. The *temperature* usually rises after death. All the *tissues* are ex-sanguine and this dryness becomes more striking as we examine those organs habitually engorged with blood, as the spleen, liver, and kidneys. The small quantity of *blood* contained in the vessels and the heart is viscid, brownish, liquid or in clots, soft and black. The *intestinal lesions* are constant, but, according to Kelsch and Vaillard, there is no relation between their intensity and the duration of the disease. They are essentially localized in the *small intestines*, but increasing in severity as they approach the cæcum. The *stomach* and *colon* are usually intact, or little affected. The first thing that calls our attention, on opening the abdomen, is the dryness and pitchy state of the *peritonæum*. The *intestinal loops* are agglutinated by a viscid, ropy layer, composed of desquamated endothelial cells, of which some have undergone mucous transformation. All the *intestinal coats* are hyperæmic, and present a lilac or hydrangea coloration. The most minute vessels are highly distended, and exhibit delicate arborizations. In some places we notice *hæmorrhagic dots*, and in severe cases true *ecchymotic patches*, extending occasionally between the two laminæ of the mesentery. Sometimes, however, and especially in fulminant cases, the hydrangea coloration is wanting, and the intestine is pale, of a grayish white color. The intestinal walls are also somewhat thickened and œdematous. In cases that run a very rapid course, the *intestine* is deprived of gas, but distended with a watery, inodorous, almost colorless fluid, resembling that of the

characteristic stools, and which contains micro-organisms, lymphatic cells, and whitish flocculi, the latter composed of desquamated epithelial cells, intact or granulous. The *solitary glands* are tumefied, or projecting, and infiltrated with lymphatic cells (psorentery). The *Peyer's patches* are still more prominent, surrounded by a hyperæmic zone, and their enlargement is more marked and more constant in children than in adults (Bard). In the majority of cases, there is no ulceration or necrotic lesions of the *mucous membranes* and *Peyer's patches*. The *epithelial desquamation* known now to be the *essential lesion* of the disease, is enormous, total, from the pylorus to the cæcum, but confined to the superficial layer. Cohnheim and his followers have considered it a post-mortem phenomenon, but the works of the last French Mission to Egypt, in 1884, have cleared us from all doubts (Strauss, Roux, Mocard, Thuillier). What in reality is purely *cadaveric*, is the shedding of the *villi*, with all their connective frame-work (Bard). The epithelium which lines the *crypts* of *Lieberkühn* is in place, and seems intact (Strauss). The connective tissue of the *mucous membranes* and *villi* is infiltrated with a large quantity of lymphatic cells, but the *muscular coat* is not altered.

When the disease arrives at the period of reaction and the *typhoid state* supervenes, the contents of the intestines are brownish, bilious, fecal-like, sometimes sanguinolent, and then we find small superficial ulcerations, sometimes *true*, follicular ulcers, that in very rare cases may lead to perforation of the walls (Bard).

The *spleen* is always small, atrophic and exsanguine (Kelsch and Vaillard). The *liver* presents anæmic grayish patches (Strauss and Roux), which are, however, found in a great number of infectious conditions, and which Doyen attributes to arrest of the local circulation. In fact, on their level, the bloodvessels have been found obliterated by leucocytes and fibrine. For Doyen these coagulations are consecutive to the arrest of the comma bacilli at these points. Great many authorities have insisted on the distention of the biliary ducts, and in particular of the gall-bladder, by a bile poorly colored and viscid. Hayem and Winter claim to have found in this liquid a toxic alkaloid.

The *kidneys* are often found enlarged and congested or presenting the first stage of parenchymatous nephritis (Dieulafoy). The cells of the convoluted tubuli have undergone a sort of turbid infiltration (Doyen), and the straight ones contain hyaline casts.

PROPHYLAXIS.—Two factors are necessary for the development of epidemic cholera, namely, *the importation of the pathogenic germ*

and a favorable soil for its reproduction and diffusion. When the migratory poison, encouraged by special conditions, makes a halt to establish a nursery, the halting-place becomes the infectious focus against which we should direct all our efforts. These should be of two kinds: *internal*, or from within; *external*, or from without the infected area. In the first case the most effective measures are: *prompt isolation of the imported cases and the immediate disinfection of their discharges and contaminated articles*; in the second, *the enactment of strict laws to prevent importation and remove those conditions favorable to the propagation of the disease*. All infected or threatened localities should pay special attention to sewers and drains, to the water supply, to food, to cooking, to diet, to temperance, to the mental state, and to private and public cleanliness. *Quarantines* would have an absolute value if they were universal and if cholera were always imported by sea. *Sanitary cordons* to prevent the introduction of cholera by land are fallacious.

PROPHYLACTIC MEDICATION.—Already in 1831 we find Hahnemann speaking on the subject as follows: “*Copper*, together with good and moderate diet and proper attention to cleanliness, is the most certain and protective remedy; those in health should take, once every week, a small globule of it (cupr. °x) in the morning, fasting, and not drink anything immediately afterwards, but this should not be done until the cholera is in the locality itself or in the neighborhood. *Camphor* cannot preserve those in health from cholera, but only the above preparation of *copper*; but when the latter is taken, the *vapor* of *camphor* must be avoided, as it suspends the action of the copper.” “It has, moreover, been found in Hungary that those who wore next the skin of their bodies a *plate* of *copper* were exempt from infection, as trustworthy intelligence from that country informs me” (*Archiv. f. hom. Heilk.*, vol. xi., 1831). In the first volume of *Bibl. Homœopathique* we find the following extract of a letter from Hahnemann to the editor: “*Cuprum* as a prophylactic against cholera has generally shown itself efficacious wherever it has been employed, and where its action has not been disturbed by gross dietetic faults or by the smell of *camphor* (which is its antidote). The best homœopathic practitioners have also found it indispensable in the second stage of the fully-developed disease, alternated, if the symptoms indicate this, with *veratrum album* x. I have also advised the alternation of these two substances from week to week as a preventive against the disease” (*Lesser Writings*, p. 756). Hering, on the other hand, recommends

sulphur as a prophylactic, both internally and carried between woollen stockings and the soles of the shoes. It suits better than any other remedy the premonitory symptoms. *Flowers of sulphur* burnt in a close room is one of our best disinfectants. Jahr regards as mere routine the methodical alternation of *verat.*, *cupr.* and *camph.*, recommended by some authorities as preventive. He praises Hering's advice, stating that *sulphur* is the only prophylactic that has stood the test of experience. He gives *verat. alb.* a first place in the *premonitory diarrhœa*, and asserts that those who took it at the first signs of purging, and did not repeat it until another attack of purging set in, remained, all of them, exempt from cholera. And finally we have *camphor* prescribed by Rubini, of Naples, in a concentrated form, not only as a specific in the early stage, but as a valuable prophylactic. It should always be taken without water, either in a lump of sugar or in tablets or disks. No report ever made by our school can compare with that of our brother of Naples during the cholera in 1866. Dr. Rubini treated 532 cases, Dr. Salustine 27, Dr. Salantanaci 56, Dr. Spitelli 80, and Dr. Ricort 1; total, 696 cases treated with the *tincture of camphor*, without a single death.

Be all this as it may, one thing is certain, and that is that *prophylactics* always produce on the mind of those who take them a sense of safety and protection, and the moral effect thus obtained is highly beneficial; consequently their employment should not be discarded if possible.

Therapeutics.—I am one of those who believe that cholera can be aborted at the *diarrhœal stage*, so during the prevalence of the disease I would advise to pay the most prompt attention to the mildest purging, and if repeated to at once order absolute rest in bed and withdrawal of all food and drink, only allowing the patient to suck ice. There are two powerful reasons why we should not lose a moment in treating any looseness of the bowels: 1, because these usually painless evacuations seen in cholera time are, in many cases the forerunners of the disease; and 2, because in many instances the patients retain their appetite and forces and keep on attending to their outdoor duties, thus spreading the disease by means of the stools, which already contain the pathogenic agent. To combat those painless, copious stools of the *prodromic stage*, I think we should study the following group: CHINA has fecal, frothy, diarrhœic, *painless stools, with much fermentation*, or white papescent at night. It is especially indicated if the diarrhœa comes on gradually and becomes more and more watery every time, with a feeling

of debility. FERRUM. The stools of this drug are watery and sudden, *without pain or smell*, especially at night and after taking water, *always with much rumbling*, or they may be thin, fecal, painless and weakening; even rice-water discharges, containing epithelial débris, with cold sweats, livid rings around the eyes, and failing voice and pulse. PODOPHYLLUM is another of our best remedies for *painless*, thin, copious, bilious stools, occurring early in the morning, with sudden urging and great epigastric sinking, a feeling as if everything would drop through the pelvis; or fecal, mushy, profuse and gushing, *with much rumbling and gurgling, with little or no pain*, driven out of bed at night. PHOS. ACID has also *painless, watery stools, with constant rumbling* in the bowels and great thirst, especially if caused by fear of catching cholera, and the patient is restless, anxious, or *apathetic* and indifferent. It is also a late remedy *if the typhoid state supervenes*, with stupor, embarrassed speech, deafness, sunken features, vacant look and utterly regardless of surroundings. PHOSPHORUS has likewise stools of a *painless and gushing nature*, either yellowish or whitish, like rice-water, containing epithelial flakes, with *burning thirst*, but the least water taken is rejected at once, and then follows *rumbling, purging and great debility*. Also *later* when the anus is wide open, allowing the escape of the stool, or in the so-called *asphyctic form*, with troublesome dyspnœa, livid face and other signs of incomplete hæmatosis. Hiccough. Lung complication. SULPHUR. Sudden attack of a *watery, painless diarrhœa*, occurring principally after midnight, or driving out of bed early in the morning; the stools are fecal, bilious, changeable, serous, frothy, with or without vomiting, with *rolling and rumbling*, and a feeling as if the bowels were too weak to retain their contents. It also covers many other early, as well as late symptoms. For sudden attacks of *painless diarrhœa at night*, ARSENICUM and PULSATILLA should also be studied. The first especially if caused by fruit or vegetables, the second by fright or pastry. If the *diarrhœa* is attended by more or less pain, I would think of IPEC., JATROPHA, CROTON TIG., IRIS, COLOC., COLCH., ELATER., and GAMBOGE. A predominant *nausea*, with or without vomiting, would point to IPEC.; a *forceful ejection of the stools* with much rumbling or gurgling to JATROPHA and CROTON TIG.; a *bilious diarrhœa*, followed by burning in the anus, and attended by severe rumbling and nausea to IRIS.; *violent colicky pains* to COLOC.; *watery, copious discharges*, containing a skinny substance, with colic and sudden sinking of strength to COLCH.; frequent, copious, *olive-*

green stools, without nausea or vomiting to ELATER.; and finally, *gushing out of thin, yellow, fecal discharges, with marked gurgling and a feeling of great relief in the abdomen after stool*, to GAMBOGE.

But as soon as the stools cease to be fecal or bile-stained, the alimentary canal commences to eject the alvine flux, cramps make their appearance, and the drain on the blood becomes manifest. We have to turn to our old, well-tried remedies, namely: CAMPHOR., VERAT ALB., CUPRUM, SECALE, ARSENICUM and CARBO. VEG. A sudden sinking of the forces, with anxiety, mental apathy, *algidity, collapse*, even cramps, but *without thirst, vomiting and purging (cholera sicca)* points to CAMPHORA. Violent ejection of the alvine flux, upwards and downwards, with sudden sinking of the forces, shrinking of the tissues, cramps, algidity, collapse, suppression of urine, but with little depression of spirits or anxiety, demand VERAT ALB. The predominance of SPASMODIC PHENOMENA (*cholera spastica*), with algidity, *cyanosis, suffocation*, and death-like collapse, as well as convulsions, indicate CUPRUM. Profuse, prostrating discharges, with painful cramps in feet, toes, hands and fingers, and *a livid, cold, dry, wrinkled, inelastic skin*, are symptoms of SECALE. *Ataxo-dynamic phenomena*, with intense agony, *burning heat in epigastrium*, and an *insatiable thirst*, which aggravates the vomiting and purging, are leading indications of ARSENICUM, and so is *algidity* with a feeling of internal heat. The *arsenicum patient* shows signs of irritability even in the last hours of life. *Death-like asthenia, with little or no reaction*, sepulchral voice, imperceptible pulse, pinched features, glacial coldness, livid surface, extreme dyspnoea, and other signs of incomplete hæmotosis, claim CARBO. VEG. as a last resort. HYDROCYANIC ACID has also been recommended in *cholera asphyctica*, when life seems extinct, the blood drained of its watery elements, the voice reduced to a whispering, the pulse nearly imperceptible, the surface cold and livid, and there is a violent hiccough, convulsions, or threatening paralysis of the heart and lungs. A neglected remedy, which I think would prove beneficial after the vomiting abates or ceases, and *retching* appears, is TART. EMET. If the retention of the alvine flux in *cholera sicca* is, as some authorities assert, due to paralysis of the intestinal walls, then I think we have in *opium* a valuable remedy. When the *typhoid state* supervenes, after vomiting, purging and algidity have ceased, and the patient is dull, with wandering looks, red, hot face, troublesome hiccough and relaxation of the sphincter ani and vesica, we should think of HYOSCYAMUS. When the *nausea* and *cold sweat* persist

after *veratrum* has stopped the diarrhœa, and the patient complains of burning heat in the abdomen, while the rest of the body is cold, give TABACUM. If the evacuations or cramps reappear, we must return to VERAT. ALB. and to CUPRUM. In the *period of reaction*, against congestion of the head, ACON., BELL.; of the lungs, ACON., BELL., PHOS., SANG., SULPH.; if the *typhoid state* supervenes, HYOS., BRYO., RHUS, BAPT., PHOS. AC., PHOS.; *deep coma*, OPIUM. *Debility after the attack*, CHINA, general; RHUS, paralysis of the extremities; PHOSPH., of the bowels. If the *urine remains scanty*, HYOS. If the *stools remain colorless*, for want of bile, SECALE.

PROVINGS AND THEIR RELATION TO CHOLERA.

BY CHARLES MOHR, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
September 14, 1892.)

WHILE old-school practitioners and their adherents may well stand aghast at the threatened invasion in this country of cholera, the homœopathic profession and laity, because of the provings of medicinal substances by Hahnemann and his followers, and the results obtained by them in the treatment of cholera in former epidemics, may regard the present epidemic in Europe and the possibility of an outbreak in America, with comparative composure. Nothing in the history of medicine is grander than Hahnemann's labors which led him to declare before he had seen a case of Asiatic cholera that *camphor*, *cuprum* and *veratrum* would be the most efficacious remedies for the successful treatment of the disease on the principle *similia*, and that they would also prove the best prophylactics. This "Sage of Coethen" was no less diligent than Andral and Broussais, and a score more of allopathic physicians, in observing and studying the course and pathology of the disease on its devastating march toward Europe. He took the same reports which reached them, but instead of theorizing to decide whether the disease was *enteritic* or *enteralgic*; or whether the remedies should be *antiphlogistic* or *antispasmodic*, he collected the symptoms given, weighed them one by one, until a picture of the hideous monster arose before him as the living reality. Then, guided by the great therapeutic law, *similia similibus curantur*, he asked himself,—what

drugs have been known to produce symptoms like those characteristic of that awful picture? With a knowledge of the pathogenesis of various drugs, possessed by no other living physician, he unerringly pointed out the trinity named above, and issued a pamphlet, giving directions for their application, and sent copies to his medical friends who were willing to cope with an enemy that was smiting to the death thousands of human beings.

In Russia, Hungary, Austria, France, England, and America, the three remedies named surpassed all others in efficacy during the prevalence of Asiatic cholera in the countries named in the years 1831, 1832, 1833, 1848, 1849, 1850, 1853, 1854, 1866, and 1873.

No disease has ever proven a better illustration of the folly of empiricism, or of the insufficiency of pathological theories, than Asiatic cholera. After the last epidemic in America, in 1873, a governmental commission, authorized to make a report upon its history, characteristics, and treatment, stated this fact: "In the advanced stages of the disease, the entire range of the pharmacopœia seems to have been brought into use with no better results than have been obtained in previous epidemics." No account was taken of the cases treated by homœopathic physicians, but of the whole number treated by allopathic physicians fifty-two per cent. ended in death.

Other theories were added to those theretofore entertained by allopathic physicians, during the epidemics of 1884 and 1885 in France, Italy and Spain, until these numbered eight, but under the old methods of treatment, and under new methods which were justified by the newer theories, the mortality reached an average of over seventy per cent. No wonder there was consternation among the people in those countries, and that the confidence of the populace in medical men was so shaken that many were driven away from the sick with sticks and stones.

What has been learned since? So far, the statistics of the epidemic in Hamburg, not to speak of Russia where the death-rate must be most appalling, the mortality is about fifty-five per cent.

Now contrast all this with the result of Hahnemann's method of treatment. In the cholera epidemic in Russia and neighboring countries in 1830-31, according to the report of the President of the Imperial Council of St. Petersburg, the total number of cholera patients under homœopathic treatment in the departments of Saratow, Tambov, and Twer, was 1273, with a loss of 108, a mortality rate of less than nine per cent. In 1832 the King of Bavaria sent a commissioner

to collect statistics, who reported that there were only 85 deaths out of 1269 cases treated by fourteen homœopathic practitioners in Moravia, in Hungary, and at Prague and Vienna, a mortality rate less than seven per cent. (In the same countries and cities, under allopathic treatment, the mortality rate was over thirty-one per cent.) In 1836 cholera visited Vienna a second time. At that time the practice of homœopathy was forbidden in Austria, but by permission a homœopathic hospital for cholera patients was opened, wherein the results were so favorable that the law forbidding the practice of homœopathy in Austria was repealed. Of the treatment in this hospital, where two-thirds of all cases recovered, while two-thirds in the old school hospitals died, Dr. Balfour, a celebrated allopathic physician of Edinburgh, on a visit to Vienna, in 1836, wrote to Sir John Forbes: "During the first appearance of cholera here, the practice of homœopathy was first introduced; and cholera, when it came again, renewed the favorable impulse previously given; as it was through Dr. Fleischmann's successful treatment of this disease that the restrictive laws were removed, and homœopathists obtained leave to practice and dispense medicines in Austria. No young physician settling in Austria, excluding government officers, can hope to make his bread, unless at least prepared to treat homœopathically if requested."

In 1848-50, Dr. Tessier in the Hospital St. Marguerite, Paris, treated cholera patients in his wards homœopathically, with a mortality rate of about thirty-four per cent., while in the other wards and hospitals under allopathic treatment the mortality was about fifty-seven per cent.

In 1848-49 in the hospitals of Edinburgh and Leith, Scotland, the mortality under homœopathic treatment was about twenty-four per cent., while the mortality under allopathic treatment was about eighty-four per cent.

In 1854, in Great Britain, the medical Council appointed by Parliament, tried to suppress the returns made by Dr. McLoughlin, an eminent allopathic physician, who was the government inspector of cholera hospitals. When the completed report was made it was found that the mortality of cholera in the homœopathic hospital in London was a little over sixteen per cent, while under allopathic treatment the mortality reached over fifty-nine per cent. The endeavor on the part of the medical council to suppress facts because in favor of homœopathy, led Dr. McLoughlin, one of their own number, but fearless and honest, to declare publicly in a letter:

"Although an allopath by principle, education, and practice, yet, was it the will of Providence to afflict me with cholera, and to deprive me of the power of prescribing for myself, I would rather be in the hands of a homœopathic than an allopathic prescriber."

In 1849 at Cincinnati two homœopathic practitioners treated 1116 cases of cholera with a loss of only 35 patients—a mortality of less than four per cent.

Let it suffice now to add that a very careful examination of reports in all epidemics proves the undeniable fact that in cholera the homœopaths have saved 91 in 100 cases, while the allopaths never saved more than 68 in 100 cases.

"This brief display of medical history shows the difficulties and failures experienced by theoretical as well as empirical medicine, in the presence of any new form of disease that is especially destructive of human life; and, also, the exceeding value of a general therapeutic principle that may cast light on the pathway of the practitioner in advance of any actual experience. Before Hahnemann had ever seen a case of cholera, such a principle enabled him to name the remedies which would meet it most successfully, in its different phases, at all times and in all countries."—Dake's *Therapeutic Methods*.

We must not be less assiduous than our old-school brethren in studying the causes and pathology of cholera. Nor must we neglect, as Hahnemann did not, preventive measures and hygienic rules. We must not stand in the way of the authorities in their efforts to shut cholera out of our country, nor fail to use disinfectants and germicides *outside of the living human body*. The destruction of the miasm, the microbes, or the comma bacillus by chemical agents, or excessive heat outside of the body is one thing, and a correct thing, but woe betide him who essays to kill the germs in the living human organism by such agents! Hahnemann knew of the "invisible animated beings" present in cholera, but he proved that the safest and best "germicide" was the homœopathic remedy—adapt that properly and the germ will die, leaving the tissues of the body uninjured. We must remember that the three remedies already mentioned are not the only curative ones—in the pamphlet issued in 1831 he named others that would occasionally be required, and other medicines since Hahnemann's time have been successfully used, when *individualization* has been practiced. *There is no specific for cholera!* There are a number of remedies that will cure people sick with cholera, when they are properly applied according to symptoms and

conditions, which are to be learned by a study of our provings; and a study of the nature or genius of the epidemic will also enable us to determine the most suitable prophylactic.

In this paper I cannot give the complete provings, nor mention all the remedies applicable for prophylaxis, or for the cure of the various stages and phases of the cholera and the complications and secondary affections attending the disease, but desire to bring to your notice the most characteristic pathogenetic symptoms of those drugs that have been successfully used in previous epidemics.

Aconitum.—Rapid collapse, deadly chill; or high fever with hard pulse; congestion to head and lungs; vertigo on raising the head; bitter, greenish vomiting; restlessness, fear and anxiety.

Antimonium crudum.—Diarrhœa at night or early in the morning, stools watery and profuse; loss of appetite, nausea, eructations, and white coated tongue. Extremely irritable.

Argentum nitricum.—Spasm of respiratory muscles, can neither breathe nor speak without great effort; suffocative sensation on attempting to swallow; fluids taken by the mouth appear to run straight through the intestinal canal.

Arsenicum.—Sudden and extreme prostration; intense thirst for cold water, but vomits water immediately; violent burning in the stomach and bowels; small, liquid stools, with burning in rectum; tongue dry, brown and cracked; urine suppressed. Restlessness and anxiety.

Asarum europæum.—Constant chilliness, cold hands, feet, knees and abdomen, not relieved by any degree of heat; nausea, loathing of food, but tongue clean; rumbling in bowels.

Bryonia.—Diarrhœa in hot weather, worse in morning and from any motion; stools brown, thin and undigested; cutting in bowels; nausea from motion; thirst for large draughts of water. Typhoidal phenomena, with pain in all limbs from motion.

Belladonna.—Congestion of brain with violent delirium; visions and illusions of the senses.

Camphora.—Great prostration; face distorted, cold and blue; hands blue and cold as ice, with coldness of body; features express despair, anguish as though suffocation was imminent; moaning and groaning, voice husky; burning in œsophagus and stomach; screams out when touched in pit of stomach; cramps in calves; nausea or vomiting or diarrhœa absent, or if present not marked; no thirst; stupid and senseless.

Carbo vegetabilis.—Extreme collapse, vomiting, diarrhœa, spasm

and pain have ceased; urine suppressed; voice extinct; sopor; pulseless; body and tongue cold, even breath is cold.

Cicuta.—Violent cramps; tonic spasms of muscles of chest; sopor.

Cinchona.—Yellow or brown watery stools; undigested stools with much flatulence, worse at night and after meals.

Colchicum.—Constant and profuse serous evacuations, with exhaustion, blueness and coldness, hoarse voice and cramps; stools of shreddy mucus with great weakness; deathly nausea; smell of food excites disgust.

Colocynthis.—Violent abdominal pains, sensation as if intestines were squeezed between stones, better from strong, steady pressure; pains in belly extend down the thighs; thin greenish, watery or slimy stools; worse after eating or drinking.

Croton tiglium.—Yellow, watery stools suddenly expelled with great force; worse after food or drink; exhaustion, faintness and vertigo.

Cuprum metallicum.—Evacuations not copious, but spasms in chest and stomach are very painful; cannot bear touch; thirst moderate; drinking allays vomiting; voice husky; respiration short and labored; urine suppressed; skin inelastic; loud gurgling in bowels, and liquids descend œsophagus with a gurgling sound.

Elaterium.—Profuse vomiting and diarrhœa; stools gushing, and containing epithelium of mucous membrane of intestines; olive-green stools.

Euphorbia.—Forcible vomiting and diarrhœa of watery fluid; sinking; anxious feeling in stomach; slow weak pulse; feet cold and affected with cramps; spasms in intestines; no desire to live unless relieved.

Hydrocyanic acid.—Rapid cases, asphyxia soon threatened; pulseless; vomiting and diarrhœa have ceased; hiccough; paralysis of œsophagus, fluids run down the œsophagus audibly; trismus.

Ipecacuanha.—Watery or slimy diarrhœa; stools fermented; greenish stools; nausea predominant.

Iris versicolor.—Vomiting and diarrhœa with violent pain in pit of stomach or around the umbilicus, burning in rectum and anus after stools; exhaustion; periodically worse at 2 or 3 o'clock A. M.

Jatropha curcas.—Violent vomiting of whitish, jelly-like substance, or like white of egg; profuse stools, watery and gushing out like a torrent; gurgling in abdomen; retraction of abdominal walls; cramps in legs and feet; marble coldness of body.

Phosphorus.—Tongue coated white; excessive thirst; vomits water shortly after drinking; belly bloated; stools watery and contain whitish lumps; oppressed breathing; sinking of strength; relieves cases where camphor has been too freely given, when there is such burning in stomach as to drive one distracted.

Phosphoric acid.—Stools light colored, liquid and copious, not painful; tongue covered with gluey mucus; cramps in arms; great sense of weakness.

Podophyllum.—Early morning diarrhœa; stools yellowish and greenish, so profuse that one wonders whence so much can come; stools contain undigested food, and smell like carrion; cramps in legs; faintness, and hollow sensation in epigastrium after stools; stools aggravated from eating and drinking.

Secale.—Face pale, eyes sunken; dry, thick coating of tongue; unquenchable thirst; burning in abdomen; watery and involuntary stools, preceded by vertigo, cramps in calves, and anguish; great aversion to heat or to being covered; unsuccessful urging to urinate.

Sulphur.—Diarrhœa comes in the night; stool, yellow, pappy, attended with great urging, but urging is sometimes ineffectual; cramps in soles of the feet and calves; pain in liver.

Veratrum album.—Diarrhœa is watery, copious and very painful, accompanied by copious vomiting, repeated every time water is drunk; face and hands cold and blue, cold sweat on forehead; voice feeble; anxious oppression of chest.

SURGICAL DISEASES.

BY J. C. NOTTINGHAM, M.D., BAY CITY, MICHIGAN.

(Read before the Homœopathic Medical Society of the State of Michigan.)

IN presenting my paper to this Society at this time I have in mind the disposition of many of us who are prone to obviate the study of *Materia Medica* by resorting to mechanical operations for the relief of diseases rather than to medicines for their cure.

Poverty in therapeutics, has been said by an eminent surgeon, to be the only excuse for operating for many of the surgical diseases arising from other causes than by traumatism, by malformation, or by surgical operation (!). (It is not pleasant for us to dwell much on the latter, remembering the statistics following laparotomies,

ovariotomies and legions of surgical failures). I would not convey the idea that I fail to appreciate the unimpeachable character and beneficence of true conservative surgery, and the humanity and true kindness of the surgeon, nor the devotion and love we all owe to the dauntless, intelligent man who provides a way for the relief from pain, deformity and inevitable death, by his arduous research and the ingenious appliances of the art.

In referring to surgical diseases I do not include injuries (surgical operations or accidents), or malformations that are manifestly beyond the reach of medicines; but those diseases which are or may be understood as an expression of a physiological error, a diathesis, taint, psora, miasm, or predisposition; whether from a latent force within, or predisposing weakness, the body is maintained in apparent health by the preponderance of healthful forces, to be developed in some organ or tissue determined by circumstances.

When the great Valentine Mott proved himself sufficiently conscientious to apologize to his class for doing operations for surgical diseases because of poverty in therapeutics, no modern surgeon can afford to be so bigoted or self-conceited as to deny that a great number of operations are done for the same reason, many for popular glamour, or for those who admire the courage and boldness of the surgeon.

Tradition has taught the people that he who can administer the largest potion of poison, or cut the closest to vital structures, without killing, is the greatest hero—the most mysteriously wise human. But the intelligent have become more rational in the subject of medicine and surgery, so that the opposite, the *cure* of all disease by the least medicine, and the accomplishment of surgery with the least possible destruction of tissue and least danger to the vital forces, is received with greatest approbation by the thoroughly informed, and this method is also attested by hospitals of the two opposite principles in general practice.

All surgical diseases have their origin in a morbid process, functional change of an organ, or diverted action, secretive, assimilative or emunctory. As certain as medicine will *cure* the *cause* of disease which resides within the organism, just so certain will it cure the effects of that cause.

On May 15, 1882, Mrs. A. G., aged 47 years, a tall, slender woman, with dark brown hair, steel-blue eyes, and a hectic flush upon her cheeks, with an expression of hopeless anxiety and suffering upon her countenance, applied to me for a renewal of medicine

which had been given her by a physician to keep her bowels soluble, in the absence of which she experienced frequent desire to stool without relief, and a fulness, with an aggravation of the intense burning which was constant in the rectum and the left inguinal region, in which was an abnormal fulness plainly visible; and upon palpation could be distinctly outlined a firm, unyielding tumor, apparently the size of a foetal head, which, she informed me, had been growing for seventeen years, accompanied by excessive periodic hæmorrhages, and had been called a fibroid tumor by seven different physicians, six being of the physiological school. She also informed me that every three months the periodic hæmorrhages were greatly intensified, and she wished I would be able to take care of her promptly at that time, when she would call me.

In the digital and conjoined palpation which she kindly permitted me to make at this time, I was quite confident that the diagnosis made before was correct, and requested her to suspend the physic she had become accustomed to take, and take instead the medicine which I would give, assuring her that if the medicine I gave her did not prove more satisfactory, and relieve her, I would consider the question of restoring the aperient medicine. In one week, patient reported a sense of relief which she had not observed in all her years of suffering. The patient was continued under treatment altogether three years, under extremely unfavorable conditions, her husband often requiring as many as five (!) and sometimes seven (!!) sexual embraces in one night, and disturbed in other respects, as a tyrant husband of this kind might be expected to annoy an intelligent but obedient wife.

There were periods of aggravation from many causes, which were met by the best remedy our judgment would suggest. The last done for her was to forcibly dilate the rectum and sigmoid flexure, and break up severe adhesions caused by the protracted pressure of the tumor and consequent inflammation, which had effectually prevented the discharge of fæces of natural consistence sufficient to prevent a rapidly increasing fulness of the viscera to such an extent as to cause great distress, besides requiring her to so limit her eating as to be very discouraging to her; her appetite now being excellent. After this was well accomplished, she experienced no more trouble, and has been usually well ever since, now being 57 years of age. There has been no drawing pains, erratic pains, or nervous phenomena incident to those related by patients after operations for these tumors.

CASE II.—J. W., aged 22, unmarried, farmer, and residing with his mother, presented himself for treatment March 3, 1878, dating his first knowledge of the trouble to three years before; exhibiting both legs. Upon the right were two large tumors of bony hardness, apparently proceeding from the tibia, and being fixed to that bone. One was located near the ankle-joint on the inner aspect of the tibia, the other near the middle of the shaft of that bone. On the left tibia were three; one on the distal extremity inner aspect, another on the outer aspect near the lower third, encroaching somewhat upon the fibula, and the third near the middle of the shaft of the tibia and outer surface pressing hard on the fibula, each appearing about the size of half a common egg. The three latter appeared most painful, and to these all attention had been given by himself and all concerned, hoping to obtain relief from the suffering, but without the slightest relief. The pain was described as a constant and severe aching, nothing more.

I prescribed for him at this time without any benefit whatever, but nearly a year afterward I was summoned in haste to go to his home, prepared to amputate his leg. Not having seen nor heard from him since I prescribed, I did not know what had occurred, and hastily went with that intention, taking with me (six miles into the country) my brother and a student, Mr. Case. Upon arriving, I found the man sitting in a chair, suffering great pain in the right knee, the bursæ being much swollen and on the inner surface quite œdematous, and a slight incision was observed which had been made by a physician who had chanced to pass by, and said he would open the abscess and go on; but he did not reach any pus or fluid. After passing his bistoury a half-inch deep, he withdrew the instrument and declared the thigh must be amputated. This alarmed the young man, and determined him to send for me and have the amputation done at once.

After making all the inquiries I could for some guide to the remedy for the cure of this condition, and when about to give up my task, I repeated the question: "Do you eat an unusual quantity of salt?" As before, he replied in the negative, but his mother, being present, corrected him, and affirmed that he ate very large quantities of salt. Thereupon I gave him two powders of nat. m. and sac. lac. to follow. Three weeks afterward he returned to work, and six months afterward every vestige of the affection was gone, with no return to date.

I have given to this society a verbal report of an undoubted ova-

rian cyst which was cured with *apis mel.*, and many such cases are on record. Even scirrhus tumors of the mammary glands have been cured by well-known remedies applied under the law of homœopathy. I do not believe any homœopathist of experience has failed to appreciate the positive, prompt and curative action of the appropriate remedy in whitlow, panaritium, ganglion, and numerous diseases of both bones and soft tissues.

All homœopathic surgeons of repute know full well the advantages of the application of the law of *similia* in cases of shock from injuries or surgical operations and complications arising therefrom, even septicæmia, pyæmia, erysipelatous inflammation or gangrene. In all these conditions met by the surgeon, the homœopathic application of therapeutics has won laurels, and in this lies the great distinction between enterprising and traditional surgery; between conservative surgery governed by a knowledge of the effective force of a correct application of the law of *similia* in surgical therapeutics and empirical methods.

I do not deny that all homœopaths are not alike successful in the practical application of surgical therapeutics; neither is any man perfect in his attainments of the practical use of the law on all occasions; hence a reason why homœopaths should be courteous to each other and seek each other's counsel frequently, treating the freedom of counsel with just approbation, with due credit, kindly reciprocation and courtesy.

THE TREATMENT OF EPILEPSY.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
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NOTWITHSTANDING the fact that I have already expressed my views concerning the treatment of epilepsy (*Transactions of the American Institute of Homœopathy*, 1890), I feel that I am not amiss in here calling your attention to it. The disease is one of comparative frequency; it is universally recognized as obstinate to treatment; and its natural tendency unchecked is on rare occasions only to spontaneous cure. In my first paper I referred to the remarkably long list of remedies that have, in the past, been vaunted as sure specifics.

I also mentioned some of the many operations which have given promise of effecting a certain cure. As to the remedies, they include some of the most disgusting agencies imaginable, so disgusting in fact as to readily put to shame the list with which the name of Dr. Samuel Swan, of New York has been so intimately associated, and which have burdened the fair name of homœopathy. In 1827 *The American Journal of the Medical Sciences*, then as now the greatest old-school medical journal in the world, contained a report on the *crista genu equinæ* (sweat scab, knee scab, mock or encircled hoof, dew claws) in epilepsy. In 1882 a western journal contained the report of a case cured by drinking the menstrual blood of a virgin. These are but examples of the desperate therapeutic measures to which recourse has been had in the treatment of epilepsy. In addition we find many drugs recommended with more or less reason, and often without any reason at all. From all of them remarkable specific effects have been alleged to have followed their use, and yet all have sunk into what is probably a well-merited oblivion.

Professional opinion seems to be unanimous in holding that epilepsy is difficult of cure, if not absolutely incurable. Exceptions are found in enthusiastic specialists and certain hobbyists, each of whom has his favorite measure that will cure "all cases." Certain members of our school have made remarkable claims of their ability to cure epilepsy and have several times quoted me the wonderful success of Bœnninghausen, who it is said, treated over four hundred cases and cured every one. I feel, and I hope that it will not be sacrilegious to thus express myself, that there is something wrong with these figures. It is hardly likely that a correct diagnosis was made in anything like all the cases, for in those days the number of diseases liable to be confounded with epilepsy was unknown. As recently as 1879, the late Dr. McClatchey taught his pupils that epilepsy need but be differentiated from malingering; and now the best medical thought teaches that epilepsy is but a symptom of many pathological conditions, and that there are many paroxysmal convulsive affections that are not epileptic. Repeated conversations with many able men have taught me that they cure epilepsy with the greatest difficulty if at all, and with this experience I am in complete accord. I believe, however, that increased light on the subject will improve methods and lead to better results.

Many of the bad results in the treatment of epilepsy are undoubtedly due to a lack of knowledge as to what constitutes the disease. An experience that is by no means small, leads me to assert

that the vast majority of cases, I might almost say all, are diagnosed in their incipiency as reflex convulsions. This error is not unnatural when one considers the stress that has been placed on the frequency of reflex convulsions by certain authorities. Specialists whose training in the domain of general medicine has been sadly deficient are likewise largely responsible for the promulgation of what, as applied to most cases of epilepsy, is a false theory. It is a good rule to regard every case of convulsion *no matter how probably reflex as possibly epileptic*. While one is generally pretty safe in deciding that convulsions not due to organic disease occurring prior to the third year of life are reflex in origin, he must not lose sight of the fact that their frequent repetition can give rise to the convulsive habit; and thus true epilepsy finds its origin. It is not a pleasant task to speak to a parent of the possibility of his child degenerating into an epileptic; and yet a strict regard for duty should lead us to give that warning; for I believe that such a warning will do much to prevent a possibility from becoming a reality. That this warning is not an idle one will be shown if one but take the trouble to investigate the early history of epileptics. In more than half the cases, probably, a history of infantile eclâmpsia is obtainable.

Convulsions occurring after the age of three years are rarely reflex. If organic disease can be excluded, they are almost certainly epileptic.

It is not always an easy matter to say what constitutes epilepsy. While the diagnosis of the disease when characterized by convulsive seizures is usually a simple matter, it is by no means such when only attacks of *la petit mal* show a departure from health. But recently a remarkable illustration of this very point was afforded me in the case of a girl of ten years, who, for six years past, had complained of peculiar "spells" which she described as "attempts to think something, only she did not know what to think." They were periodical in their recurrence, lasted but a second or two, and were accompanied by loss of consciousness. During the six years she had been under constant medical supervision without any successful result.

And right here let me give a little piece of advice that should be adopted as a routine measure in managing every case of epilepsy: Direct your patient to keep a day-book. In this book should be recorded the number of convulsions, their characteristics, time of onset, duration, attendant circumstances, etc. All morbid phenomena occurring between seizures should likewise be carefully noted. Such

a book has a two-fold purpose. In the first place it affords us a certain amount of help in treatment of the case, not otherwise obtainable; and in the second place it is invaluable as indicating most certainly the progress made. Certain hospitals treating large numbers of epileptics have specially prepared charts for indicating the number of convulsions. By means of this device one can see the course of the disease so far as it relates to the number of the convulsions, at a single glance. Without some such record as the day-book or chart, any testimony as to improvement or cure is more or less unreliable.

When once epilepsy has been developed, the plan of treatment which must be followed must include careful observance of all the rules of personal hygiene, including regular habits and careful dieting, removal of all possible sources of irritation, and proper medication, and in suitable cases surgery.

Considering first the question of diet, we come to one of the most important items in the treatment of epilepsy. Some authors do not hesitate to make this the first in importance. Here we find authorities at variance, according as they take this or that pathological view of epilepsy. Seguin, Gowers, and others taking the ground that the nervous system should be fed with the strongest food, as in neurasthenia, do not hesitate to strenuously advocate a diet into which meat enters largely. Haig, believing that epilepsy is a disease resulting from the uric acid diathesis, prohibits meats; others while not agreeing with Haig as to the origin of epilepsy in uricæmia, consider the meat diet positively harmful as promoting a convulsive tendency. Clinical facts seem to favor the latter view, in my opinion. I think it wise, therefore, in the majority of cases to keep epileptic patients on a mainly vegetable diet, allowing milk regularly, and poultry and fish on rare occasions. Even the administration of liquid preparations of meat, as soups, broths, peptones, and the like, has a bad effect on the epileptic. I have been assured by those in charge of institutions receiving epileptics that these cases are almost invariably made worse by such a diet.

Of far more importance than the general character of the diet is the quantity eaten, and the manner of taking it. Nothing is more harmful than overloading the stomach, especially with articles proverbially indigestible. Above all things the food must be slowly eaten. These are directions which will require the greatest care to enforce, for epileptics usually have ravenous appetites, and exhibit no judgment whatever in satisfying them.

It is needless to say that indigestible foods and mixtures, as pastry, mince pies, etc., etc., should be forever eschewed.

In cases in which the seizures are almost invariably nocturnal, the evening meal *must* be taken as early as possible, and should be of the lightest possible character.

In every case the relation of attacks to diet and times of eating should be carefully studied, and our advice should be governed accordingly.

In thin anæmic cases, cod-liver oil is a positive necessity.

Alcohol and alcoholic preparations are positively harmful.

Dancing, swinging, and other amusements likely to influence the cerebral circulation deleteriously must be forever forbidden. One patient in whom I had been fortunate enough to keep the attacks away for over a year had a relapse from using a swing.

One cannot lay down any hard and fast rules concerning occupation, general amusements, etc., as each case must be studied *per se*.

The general care and management of epileptic patients is a matter of unrecognized importance. Here, I use the word care to include "discipline" as well. Parents lack firmness and wisdom oftentimes in the management of their own, and by injudicious "coddling" do much to render ineffective well-directed efforts of the physician at cure. Many times the best results can only be obtained away from home.

Sexual hygiene is an important matter. I entertain very serious doubts that sexual excesses ever caused epilepsy, though it is certain that they aggravate it if it once develops. Epileptics are unquestionably great masturbators, probably because the disease produces a mental degeneracy that leads to that sexual vice. Masturbation, then, must be stopped. The nearer the patient comes to celibacy, the better it will be for him.

This brings me to an outside question concerning sexual hygiene to refer to which here, I take the opportunity. It has been often suggested that sexual intercourse is an absolute necessity without which perfect health cannot be attained. In proof of this many believe that after certain patients, male or female as the case may be, have been gratified sexually, there will be a general improvement in health. In keeping with this view, women are advised to get married, though in an unmarriageable condition, and men are advised "to go out." So far as epilepsy is concerned this is pernicious advice. I do not believe that any epileptic was cured by it, and many have been harmed. I believe the same to be true in the treatment

of other neuroses. The only neurotic that I ever treated who was benefited by intercourse was one who was living under abnormal sexual conditions. He was a clergyman, who not wishing his wife to become pregnant refrained from intercourse; but he continued to room with her. After some eighteen months of continence, he became hypochondriacal, imagined himself impotent, and had a host of symptoms with which we are all familiar. His nightly association had served to keep up an almost constant sexual excitement which not being gratified found its vent in involuntary emissions. He was advised to gratify his desires, and then room away from his wife. The result was a perfect cure. In the majority of cases of neurasthenia we have to deal with excess and not continence.

It is an important matter to keep epileptics from dangerous places.

The reflex origin of epilepsy is a fruitful source of discussion. It is one of those questions to which the old couplet

"A man convinced against his will
Is of the same opinion still,"

most truly applies. Physician after physician can tell you of cases that he has cured by this or that minor surgical procedure; and yet the details are barely more complete than they should be for a well-told anecdote. One friend told me that he had cured twenty-two out of twenty-five cases of epilepsy by orificial surgery. If his success was so remarkable as this, it certainly exceeds anything else known to medical science, and it is his duty to publish these cases with the most careful attention to details. I trust that this will lead him to do so. Another man can tell you of countless cases cured by circumcision. Our friend the oculist, may tell of cases cured by fitting for glasses; the aurist, of cures effected by attention to the ears. The neurologist, notwithstanding his careful attention to all possible sources of irritation, says that he cures his cases with the greatest difficulty, and in exceptional instances only. For awhile, the gynecic surgeons were oöphorectomizing the poor helpless epileptic. So far as my knowledge of medical literature goes, I know of no case in which a permanent cure has been effected by this operation other than in those to which I shall refer presently.

It is a wise plan to remove all possible irritation from the areas of distribution of cranial nerves. In keeping with this idea, teeth, eyes, ears and nose should be carefully examined and kept in order. Under no circumstances should the wild fads and fancies of the

Stevens school of ophthalmologists receive sanction. Muscular anomalies may be found occasionally, and should, of course, receive *scientific* attention; but under no circumstances should the wild resort to indiscriminate tenotomy be advised or permitted.

Circumcision is wise as a preventive of masturbation. It is necessary when the redundancy is the cause of local irritation, or where there is an obstruction to the escape of urine. Circumcision is not an absolute preventive of self-abuse, as the habit is not uncommon among Jewish boys.

Many measures have been recommended for the abortion of the fits. Ligation of an extremity when the aura begins in that part has been practised with some success. In similar cases blisters encircling the arms have likewise done some good. It is an interesting as well as noteworthy fact in these cases that after the fit has been stopped at the site of the ligature or the blister several times, it acquires the habit of ending there in subsequent attacks, though there be no mechanical device there to prevent it. Of course, this relief is but temporary.

Nitrite of amyl has been used as a preventive of attacks, but it is beneficial in a very small percentage of cases.

The use of salt and other agents during the spasm does no good. The fit must run its course.

The only treatment applicable to the convulsive stage is that which will protect the patient from injury.

The medicinal treatment of epilepsy, viewed from whatever standpoint we may, is not in a satisfactory condition. From our homœopathic remedies we do not secure any regular results, while the bromide of potassium is in most cases but a palliative.

As to *cœnanthe*, *cicuta virosa*, hydrocyanic acid and other so-called specifics, I have never seen one favorable result, notwithstanding the large number of cases in which they have been administered. It is but just to say, however, that they were given only in dispensary cases, in which class one must rely almost exclusively upon drug treatment, for dispensary patients have neither the intelligence nor the disposition nor the means to pursue a proper hygienic course. The most successful medication seems to be that in which the aim is to keep the general health up to the highest standard. *Nux vomica*, *belladonna*, *pulsatilla*, *bryonia* and like remedies are not only valuable, but necessary.

Much has been said of the tissue remedies. I have tried Schüssler's *kali mur.*, but without the slightest sign of success. *Silicea*

and calcaria carb. and sulphur have apparently done considerable good when systemic conditions indicated those remedies. Argentum nitricum in one case effected a cure that lasted two years, when there was a relapse. I know nothing of the subsequent history of the case.

In the case of failure to get epileptic seizures well under control within a reasonable time, there should be no question concerning the resort to bromides. Bromide of potassium has been abused to such an extent as to deter the timid from its use. It has been accused of producing a condition far worse than the original trouble for which it was given. Physicians of all schools unite in its condemnation. And yet if the drug is used with judgment, it is the greatest boon certain epileptics have. When it is suited to the case—that is to say when it is given in cases in which it causes a cessation of the convulsions—it most assuredly improves the mental faculties instead of depressing them. I have seen this over and over again. There need be no fear of giving large doses. One of the reasons for failure hitherto with most physicians is that the maximum dose given is but thirty grains daily. In the majority of cases such doses are inefficient, and, unless they control the fits, must show a depressing influence on the mind. When, however, an efficient dosage is adopted—and by efficient I mean quantities sufficient to keep the fits away entirely—one will be astonished at the improvement in the patient's general condition.

One naturally views the effects of bromides in epilepsy according to his individual experience. I do not wish to convey the idea that the drug is without ill-effect in all cases, or that it is always curative or even palliative. On the contrary, I know this is not the case. But there are a large number of epileptic patients whose natural tendency is towards dementia. They are desperate cases, and they go from bad to worse. Most of them have organic cerebral disease as their anatomical substratum. No drug will do them one iota of good. Yet they have been dosed, not only with bromide, but with every conceivable drug under the sun. Quack medicines have been administered by the score, and bromides have been administered by the five cents' worth, without the sanction of a physician. Is it any wonder that such cases end in the asylum? At home their friends are often too lazy or too poor to give them the proper care, and this only adds to their miseries. Such cases are often met with as well in the families of those who are careful, but here good treatment does much to prevent the terminal dementia.

In dispensary practice one meets with a middle class of patients who follow advice perfectly so far as it relates to medicinal treatment, but who will not or cannot obey general directions. Such patients cannot expect to obtain the best results from carefully-given medical advice.

If one wishes to avoid bromism, and would carry the palliative treatment of epilepsy to its greatest efficiency, he must pay the greatest attention to the minutest details. The fact that epilepsy is best treated palliatively by bromides should not lead to routine carelessness.

The dose that will be efficient in any given case can only be decided by careful observation of that case. Repeated visits to the physician, I might almost say daily visits, are necessary to decide this point. The smallest dose that will suppress the seizures is the one to employ. I would not be satisfied with a partial suppression. I would aim at making the suppression absolute. Of course, this result can be obtained only in a minority of the cases; then one must be satisfied with the dose that produces the maximum effect without exciting bromism.

One of the unfortunate effects of bromide of potassium is its tendency to disorder digestion, an effect, too, that has more to do with the production of bromism than appears at first sight. We have two measures that obviate this to a great degree, namely, large dilution of the dose and the administration of the drug in a feebly alkaline mineral water, as Vichy. These are highly important points, which must be observed in every case. Given thus, the medicine is much more rapidly absorbed. It should likewise be drunk slowly.

It is better to give the drug in as few doses as possible. I would never give it oftener than three times daily. With the majority of people it is a difficult, if not almost impossible matter, to get them to take medicine regularly over any great length of time. The longer the intervals between doses the more have we reason to expect regularity. As to the times at which the drug should be given, we must be governed by individual cases. One dose should be given as early in the day as possible; while another should be given at an hour about from four to six hours before the usual time at which the fits are likely to occur. Gowers has recommended one large dose daily, and that dose to be taken at bedtime.

One can never, and I mean never most emphatically, entrust the administration of the drug to the patient himself. I never saw an

epileptic who would take his medicine regularly unless he had some one to attend to it for him. This is true, notwithstanding the strongest incentives to recovery ; it becomes more forcible when medicinal action has secured an all but permanent cessation of seizures. Epileptic patients are their own worst enemies.

Having once begun the administration of the bromides, it is necessary to keep them up steadily for years. It has been said that a case cannot be considered as cured until the fits have remained away for three years. I would err on the safe side, and say that one can never say when a case is cured. The fits may have remained away for five, nay, even ten years, and yet a relapse may occur. I would insist upon continuous medication for a period never less than three years after the last seizure, and, if possible, I would keep the patient under the drug for five years. I do not know but that if I were an epileptic I should insist upon taking it all my life.

In female cases, in which the attacks seem to recur more frequently about the menstrual periods, it is advisable to give the drug in larger doses then than at other times. I should say here that the aggravation of attacks about the menses does not by any means signify a reflex origin of the disorder.

Bromic acne has been greatly feared. This deleterious effect of the drug should not occasion the slightest anxiety. It may be entirely obviated by the administration of Fowler's solution of arsenic. The bromic acne is not an index of the physiological effect of the drug. The readiness with which it is produced depends largely upon peculiarities of skin structure.

Some patients are more susceptible to the unpleasant effects of bromide than others. While small doses exert a depressing influence in a few, there are others who can take the most extravagant doses without a symptom being produced thereby. Other things being equal, children seem to be able to withstand bromism better than adults. Small, delicate people, people with organic heart disease or feeble circulation, or epileptic cases depending upon organic disease of the brain, stand bromides very poorly. Under all these circumstances the drug should be administered with the greatest care, as unpleasant, if not dangerous effects, may be produced if its use is persisted in.

Even after having decided upon what is apparently an efficient dosage in a given case, it is not wise to let the patient keep on with the drug without medical supervision. There are circumstances that indicate diminution or increase of dose. In the case of any in-

terrecurrent illness, medical or surgical, the large doses are not so important, for illness and surgical operations and accidents are of themselves most efficient anti-epileptics. The drug should not be discontinued, however, excepting in the case of an acute illness of a most depressing character. Patients who are subject to exacerbations and ameliorations of attacks in certain seasons of the year should have the dosage regulated accordingly. Increasing age and size of young epileptics will require a gradual increase in the dose. An extra dose should also be administered when patients have experienced any unusual excitement or fatigue.

If all the above rules are carefully followed, I am satisfied that bromism will, in a great measure, be robbed of its terrors. Unless they are followed in the minutest particular, the best results from the drug will not be obtained.

There has been much discussion as to which of the bromides is the best. I do not think that this question is one of much importance. What one will not do, the other certainly will not.

Seguin has recommended, in case of the failure of the bromide to control the seizures, that a portion of that drug be replaced by a certain amount of chloral. His rule is to substitute five grains of chloral for every ten grains of bromide displaced.

Bromides are not as efficient in controlling the mild epileptic attacks as they are in the case of the convulsive ones.

As to the bad effects of bromide upon the mind, I think, as I have already hinted, that they are largely overdrawn. The great trouble is that epilepsies are not properly differentiated. Certain types are invariably associated with the highest degree of mental degradation, while cases exist in which the most brilliant intellect is to be found. It has been said that Julius Cæsar and Napoleon Bonaparte were both epileptics. These cases, however, are exceptional. The natural tendency of epilepsy is to produce mental deterioration proportionate to the severity of the disorder. This fact was well recognized many years before the bromides were introduced as medicine. One should not be too ready, therefore, in ascribing the dementia in a given case to the effects of the treatment, rather than to the course of the disease.

No disease has more bones of contention as to its treatment than has epilepsy. Not only the bromides but the surgical measures proposed for its relief have been discussed, often indeed with a spirit that is far more acrimonious than scientific. There can be no ques-

tion that some cases have been cured by the removal of reflex irritation, but these are exceedingly few and far between.

The brilliant successes of abdominal surgeons have led to indiscriminate oöphorectomizing of epileptic patients, a practice that, so far as I am aware, has not been fraught with one cure, excepting in some few cases where there was severe ovarian disease. I consider it a practice that should be condemned in unqualified terms to remove healthy ovaries for the cure of epilepsy and other neuroses. Practical experience of the best and most experienced gynæcologists and neurologists bears out this view. It is true that cases of cure have been reported in medical journals, but the reports have usually been made altogether too soon after the operation. No case of epilepsy can be considered as having been cured by an operation until two years have elapsed without a fit of any kind.

If oöphorectomy is a proper procedure for the cure of epilepsy, castration is also in the case of male patients. If we are to believe writers, it has much to commend it, for, so far as I am aware, every case thus far reported in which it has been tried has resulted in a cure. But in justice to epileptics, let me say that these reports are valueless.

The general impression as to the prognosis of traumatic epilepsy treated by operation is decidedly incorrect. Books teach and physicians believe that a trephining in a case of traumatic epilepsy is tantamount to cure. No greater error was ever promulgated. A small percentage of traumatic epilepsies are permanently cured by trephining. Nearly all experience a temporary relief from the operation. This relief, however, is merely that which follows any surgical procedure done on an epileptic. I have taken the pains to read over the reports of a large number of traumatic cases operated, and I must say that the same degree of carelessness manifested in other reports would bring upon the author a well-deserved rebuke. Thus I find an article headed, "Epilepsy of Ten Years' Standing; Trephining; Cure." Reading the article, I find that the convulsions had evidently occurred as the result of an old traumatism, probably a fracture; that the case had been trephined at the seat of fracture, and that up to the time of leaving the hospital there had been no recurrence of the seizures. It is surprising, moreover, to find that the men making these incomplete reports are men of intelligence and learning. Occasionally, however, we find reports of cases really cured. While I have not analyzed the reports sufficiently to give statistics, I feel safe in estimating the proportion of cures of traumatic epi-

lepsy at not over 20 per cent., and I would not be surprised if they did not reach 10 per cent. Results might be better if the cases were better selected; in fact, I am sure of it. In a general way it is a safe rule to trephine all cases at the seat of injury in which the relation of cause and effect between the injury and the epilepsy is well established. We have not much reason to expect a favorable result unless the convulsions present characteristics that indicate a local seat of disturbance. In every case we cannot be too careful as to how much we promise.

Sachs endeavors to account for the unfavorable results from trephining for epilepsy on the theory that a secondary sclerotic condition is set up by the injury. There is much to favor this view. He thus explains, I am satisfied, those cases of traumatic epilepsy which are apparently dependent upon a general cerebral disturbance.

Sachs's remarks at once raise the question of prevention of epilepsy after head injuries. If we cannot cure traumatic epilepsy, can we prevent it? I do not think we know enough to answer this question. It has been said, by whom I do not now just recall, that 50 per cent. of head injuries develop epilepsy in later years. I have before quoted this remark approvingly. More mature consideration leads me to doubt it; but the percentage is undoubtedly large. Let the figures be what they may, our course is the same. Every case of fresh cranial injury should be treated according to principles that will give the parts the best chances for perfect healing. I believe it to be a good rule to trephine all fractures where there is the slightest evidence of brain injury. There may be no depression of bone, but there may be a sub- or extra-dural hæmorrhage, attention to which is an important matter. On the other hand, one must not promise that trephining will certainly prevent epilepsy, for cases have been reported in which the simple operation itself has been the traumatism that started up the disease.

Early operation should be performed as an exploratory procedure primarily. Secondarily, it acts beneficially by relief of tension.

Aside from traumatic cases, trephining has been recommended in certain types of epilepsy presenting a local origin. It has also been recommended as an empirical measure in idiopathic cases. All cures reported in the latter class are not satisfactory, the reports having been made too soon after operation. Sometimes most remarkable primary improvement occurs. This was well illustrated in a case recently under the care of Dr. Van Lennep and myself. The child had been having thirty to forty convulsions daily. Large

doses of bromide given in order to suppress as far as possible the general character of the fits leaving the special character still predominant, only served to reduce the number to fifteen or twenty daily. A trephining over the middle of the fissure of Rolando, on the side opposite to that on which the convulsions were most marked, was performed. In the two months after the operation the child had but two attacks, and they were within the first week or two afterwards. I do not know what the final result has been.

Jacksonian epilepsy is the form of the disease in which surgery has been offered as the sovereign remedy. Experience has not borne out the promise of good things made. Improvement has followed in most cases; but relapses have been common. The paralyzes following the excision of a cortical centre have, in most instances been temporary. The late histories of those cases in which I have been interested have not been what was hoped for. But yesterday I saw one of these cases that had been operated upon nearly two years ago. The report is: Temporary improvement in number of convulsions; remarkable improvement in all the mental faculties; severe neuralgic pains, having their focus at the old seat of operation. Another case that pursued a brilliant course for three months had a convulsion the day after leaving the hospital. Concerning the subsequent history I am ignorant.*

Official surgery has been recommended as a cure for epilepsy. I have had three cases treated thus, and with failure in each instance. I am inclined to view this procedure, so far as it relates to epilepsy, as only a measure for the removal of local irritation. Yet I am not unmindful of the claims made by my Southern friend referred to in the early portion of this paper, who cured his twenty-two cases by surgical procedures alone.

Ligation of the vertebral arteries and other operations have been recommended, but have been abandoned.

Thomson, of New York, has recommended the employment of a red-pepper pack as a therapeutic measure. It is supposed to produce general peripheral irritation and exert the same influence as major surgical operation.

Actual cautery applied to the head has not been without its ad-

* Since writing the above I have had the opportunity of examining a similar case extensively quoted in medical literature as a cure. The result to date is: "Entire cessation of attacks for a number of months after the operation; return of convulsions to nearly their former frequency; permanent and remarkable improvement in the mental condition."

herents. Falling against a stove while in a fit has effected temporary cures.

There is one thing to say concerning operative treatment of epilepsy. So much is expected from the operation itself that nothing is done afterwards to maintain the improvement. This is a serious mistake. I suppose we must put up with it while people are what they are. Still, we should fight it.

Epilepsy undoubtedly sometimes recovers spontaneously. As I pen these lines a medical friend tells me of three cases which he knows were permanently cured by time, diet and well-regulated habits.

In the preceding pages I have given my ideas as to the proper treatment of epilepsy. Let me say that they are the result of experience in managing the pick of obstinate cases. But few of them have been of recent origin. There is much more to be said on the subject. There is much to be learned. We cannot become wiser, however, if reports are presented in anecdotal style, with but little attention to detail. We want facts and histories of cases extending over years. Anything short of this is unsatisfactory. When this is done, I believe our results will be better, and epilepsy will be robbed of many of its terrors.

SOME THOUGHTS CONCERNING MEDICAL ORGANIZATION.

BY G. MAXWELL CHRISTINE, A.M., M.D., PHILADELPHIA.

(Read before the Germantown Medical Club, August 15, 1892.)

ON every hand are unmistakable and indisputable evidences of the excellent returns resulting from organization among the trades, callings and professions of men. Though here and there mistaken zeal and bad leadership carry organizations of this kind into errors of judgment and the perpetration of grievous wrongs, the principle underlying them is none the less worthy of exemplification. It is natural to suppose that men of common thought and common purpose, if banded together, can think, labor, and accomplish better results, than if each individual should strive alone. Human achievement of any kind, is made up, it is true, of individual thought and individual action; but each individual often finds in

the thought of another an incentive to his own thought, and in the intention of another inducement to carry out his own intention ; in the helpfulness of another, he seals the success of his own plans and purposes. Only the hermit, who isolates himself from all mankind, finds no apparent need for the stimulation and helpfulness given by association with other men ; yet we may venture to think, that even the hermit must occasionally yearn for the communion and sympathy of his kindred. When left to his own individual resources, a man is indeed weak and accomplishes but little. He needs the sympathy, the advice, the help, the encouragement of his fellow-men ; he needs to be one of the many who are striving in association together to accomplish results ; he realizes that man is not an independent creature, but is dependent on his fellow, just as his fellow is dependent on him in return. Life is collective and mutual.

The home is the basis of all association ; from it springs society, which brings men together in social relation, the church which binds men together in religious ties, and the State which holds men together in law and order.

As men go out from their homes into the business world, they find it necessary to utilize the value of association in advancing the interests of their special callings. The painters, the workers in gold, silver and iron, the merchants, the lawyers, the ministers, the doctors, even governments, unite themselves for mutual good ; and in doing so they but follow the most natural and sagacious of laws. The grouping of men in the laboring, business and professional world, demands that each group, while recognizing the interdependence of human action and achievement, places a true value on that law which makes self-preservation one of the first laws of nature. Therefore, an association to advance a common interest, if it be without an intrusion or invasion of the rights of others, is both wise and natural.

Thus much by way of a prelude to remarks I want to make to-night respecting the organization of homœopathic medical and surgical practitioners into societies for the advancement of the art they practice, and for the protection of the rights they do or should enjoy.

A few weeks ago I took part in a debate held in the County Medical Society of this city. I then maintained that all medical societies in this country and the world over, coming under the head of homœopathic, should be so organized as to be related to each other, and not distinct and separate as I believe they now are. My

argument was that the County Medical Society should be the foundation on which all other organizations should be based. In speaking of medical clubs I advocated that instead of being separate organizations, it would subserve a better purpose and be productive of more definite and enduring results if they were related in some way to county societies. In other words I advocated that in matters pertaining to medical organization, the profession should work together, its several organizations being so related and so interdependent as to make a force working in unison and for the furtherance of the interests of our profession in all its bearings. I can understand how medical clubs of the strength of number and power such as it is your privilege to enjoy, could be factors of immense service to a county medical society, if in some way they could be associated with it.

I am your guest to-night, and for the second time I enjoy the hospitality of which I had heard so much and to which I can now bear personal knowledge. I find you not only bent on enjoying the good things to which a liberal provider invites you and your guests to partake at the close of this portion of your exercises, but also on gaining all the information you can on the topics which from time to time are presented here for discussion. In this respect you are a power for good, and no man can say of you that you are not fulfilling an excellent mission. Whether the strictures which in debate I placed on your clubs, are warranted by the facts, or whether Doctors Bartlett and Dudley in maintaining that medical clubs are not inimical to county medical societies, presented the true phase of the question, the fact remains, that, if all medical clubs are like yours, they do much toward filling a want in the profession, and are to be commended for their zeal, energy and manifest determination to advance the cause of medicine and materially help the profession. I only want to throw out the hint, that, by the union of such clubs in some representative manner with the County Society, they could aid the society, aid themselves, and in many ways further the various plans initiated and fostered by the County Society. I believe you could be very excellent children to a most worthy parent.

Even with the fear of being wearisome, let me particularize a plan upon which I think medical organization in the homœopathic school should be based.

But, let me lead up to the plan by stating the present character of medical organization, so far as it pertains to the thought of this paper.

In this city there is one County Medical Society, which except in the matter of sending delegates to the State, National and International Societies, but for what purpose I am not certain in my knowledge, has no relation to any other of the *major* societies, nor has it jurisdiction over any of the several *minor* medical societies in the city or county.

In this State, there is a State Society, membership in which can be secured, I believe, by the recent graduate without any certificate of membership in a county society, or proof of service rendered the profession. The State Society has no relation to the County Society and does not pretend to exercise any fostering care *over* that society. Whilst presuming to be a State society, it still does not, according to my way of thinking, fulfil its true mission, in that it does not extend its influence into the various counties of the State, by seeing that each county has a society and by requiring of each county some form of allegiance.

In the United States, we have a national association to which any doctor of the homœopathic faith can belong, though the signatures on his diploma be scarcely dry, and though he be unable to show a certificate of membership in either a county or State society. In so far as I know, this National society has no supervision over the State societies, and makes no effort to effect State organizations throughout the Union.

There is an International Association which has the same faults of construction as that of the National and State societies.

These organizations seem to have fallen short in several particulars of what under a different plan of organization they could have accomplished. I do not characterize them as weak and as effecting no result; on the contrary, they have achieved a wonderful work, have impressed themselves on the profession and on the public as factors for great good, and have brought the members of the profession into a close and intimate relation. But the question naturally arises, has this disjointed organization been as productive of good as one would wish; has this city been sufficiently organized; have all the resources of the profession here been developed, all its power utilized, under the administration of the County Society? Has the State Society been the parent to State interests she should have been, and would have been, had she extended her mission into every county of the State? Has the National Society aimed to have every State and Territory working for the common cause?

What is the International Society doing in this direction?

Among other ends in view, the homœopathic profession seeks that which shall advance homœopathic art and science, and that which shall secure for it that recognition by the law and the people of those rights to which it is justly entitled. If organization did nothing else than assist the profession in these two directions, it would be worth all the effort; for these are the foundations on which will rest all other results. That so much has already been done in homœopathy along these lines, is due, I venture to think, more to individual than to united, organized, effort.

As now organized I do not wish to detract from the credit due our various societies, but I believe their present environment has limited their action, and whenever there is limited action there is of necessity limited result. The homœopathic profession in this country is a power, but it is a power not yet under efficient and satisfactory control. There are fields we have not tilled, and awaiting harvests we have not yet garnered.

To my mind, and I cannot reiterate it too often, the County Society should be so co-related to medical organization as to support everything above it, and foster everything below it, and being therefore the most important of all the several medical organizations, it should be constructed on lines of strength and permanency. Not only should one general feature in the conduct of such a society be observed, but every feature likely to be of service or of good to the profession should be given consideration. The practice of medicine is general and special. The County Society has, therefore, a general and a special field of action. The one should not be allowed to absorb too much attention to the detriment of the other. The members of the profession, within the limits of the county, should be a unit in seeking membership in the County Society, but that membership should be possible only under strict conditions. In addition to the conditions imposed by our County Society, I would make it obligatory on the prospective member that he shall have practised the homœopathic system of medicine in the county for the space of at least two years. I will even go so far as to limit membership in the County Society to graduates of homœopathic schools. A county society with a membership small in proportion to the total number of the profession in the county, or with but a fractional attendance of its total membership, is significant of the incapacity of those entrusted with the success of the society, and reflects on the members themselves for their lethargy and on the profession at large for its non-appreciation of membership in a soci-

ety of this kind. A county society should be a means of education for the practitioner, and should take his studies up just about where he left them off when he graduated.

Let me express the belief that the State Society would be stronger, more efficient, indeed more popular, were it based on membership in the County Society. It seems anomalous to permit membership in the State Society to be secured prior to membership in the County Society, and yet I believe this is possible in our State Society. It seems to me that it would be a great element of strength if membership in the State Society should be dependent upon membership in a county society. I think of no objection to such a pre-requisite, not easily overcome. County societies should be made to report to the State societies yearly. The County Societies all over the State would thus be under the supervision of the State Society. There is very little doubt that the various county societies would cheerfully enter into an arrangement of this kind, an arrangement which, in my judgment, would largely result in profit to the profession and to medicine. Every county having homœopathic practitioners would be encouraged to have its county society, if only two physicians belonged to it. If any county had only one practitioner, and he wanted to get into the State Society, an exception could be made to meet such a case.

The National Society should be composed of members of State Societies, or even of the various county, or other recognized medical societies. Reports should be regularly made from the State societies, so that a sort of supervision could be had over the profession.

One great international society should cap the whole structure of our medical organization, and membership in it should be contingent on association with national societies, provided they existed.

If this plan to which I have made reference could be carried out, what a glorious balance sheet could be drawn at the end of the year of work done in homœopathy! How easy it would be to direct, and in a large measure to control, homœopathy in this country and the world over!

CACTUS GRANDIFLORUS has neuralgic and other forms of pains, which are sure to appear when the patient misses an accustomed meal.

A STUDY OF THE PROGNOSIS IN PREGNANCY AND LABOR WHEN COMPLICATIONS OF CARDIAC LESIONS OCCUR.

BY J. NICHOLAS MITCHELL, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, September 15, 1892.)

THE prognosis in cases of pregnancy, where cardiac complications occur, is a subject which is treated of in a rather unsatisfactory manner in most of the text-books on obstetrics.

There is a great diversity of opinion expressed, but, in a greater number, one may conclude that such complications are considered as very grave, and authorities generally agree that the most frequent lesion encountered is that of mitral insufficiency, but that mitral stenosis, while rarer, is a much more serious matter. Endocarditis is mentioned by many authors as a not infrequent disease during the puerperal period, and some have described cases where sudden death has occurred even as late as the tenth day after confinement, caused by a clot formed in the heart, suffering from endocarditis. Aortic incompetency is, also, by some considered as a most dangerous complication, Playfair placing it as second on the list in danger while agreeing with every one else in placing mitral stenosis first.

Lusk says: "Mitral lesions are of more grave significance than those at the aortic orifice, and mitral stenosis is particularly dangerous." Both Playfair and Lusk advise against marriage when cardiac disease is discovered beforehand.

In Dr. Berry Hart's valuable study of the subject of mitral stenosis in relation to the third stage of labor, as quoted by *The American System of Obstetrics*, from the *Edinburgh Medical Journal*, of February, 1888, we read: "That mitral stenosis is a serious disease apart from any pregnancy, inasmuch as the weak left auricle soon fails in its increased duties, the lungs become engorged, and the right side of the heart dilated." He holds, "That if free hæmorrhage does not occur during the third stage of labor, there is returned to the right side of the heart the extra amount of blood before accommodated in the uterine and placental sinuses; hence the right heart is dilated, distended, and pulmonary engorgement is present."

Charpentier, who gives this subject more consideration in his work than many other authors, says: "Disease of the heart shows its influence in pregnancy by causing metrorrhagia, premature labor,

and abortion, and by causing the death of the foetus either directly, on account of the mother's affection, or, in consequence of changes in the placenta." He quotes Duroziez, as having reported 21 cases of miscarriage among 41 women with heart disease, and says that among 220 cases, collected by Couréjol and Porak, 128 were delivered at term. In speaking of the prognosis, he considers it as grave both for the mother and child; varying, however, according to the different lesions. "Mitral lesions unquestionably," he says, "are the most serious of all, although opinions differ with regard to stenosis. When the latter is combined with insufficiency the prognosis is much worse."

He quotes Porak's now famous table of 92 cases of heart disease, 35 of which terminated fatally. The mitral being affected in 54, aortic in 13, and both valves in 22 cases; the foetus was expelled prematurely in all but 3 cases. Mitral stenosis, according to Porak, is a very serious affection, often terminating fatally.

King, in the fifth edition of his *Manual of Obstetrics*, says, after describing the symptoms of some of the different diseases of the heart: "The mitral lesions are worse than aortic; mitral stenosis is more grave than insufficiency. The worst cases of all are those in which mitral and aortic lesions coexist. . . . Women with known valvular disease should be advised not to marry. Should such a one pass successfully through the dangers of one pregnancy, then she should be thoroughly advised of the greater dangers of succeeding ones."

Leavitt says: "The most serious valvular lesions here, as in the non-pregnant state, are, 1, mitral stenosis, and, 2, aortic insufficiency. In those cases wherein the pathological conditions have developed during pregnancy, when once the disabled heart has weathered the storm of parturition, the abnormal symptoms usually subside; but, when pregnancy has merely aggravated pre-existing disease, the patient is extremely liable to sink during the puerperal period. Women who are the subjects of serious cardiac lesions ought not to be advised to 'marry.'"

Opposed to these views we find that Reynolds says: "Mitral lesions are more dangerous than aortic; and, of mitral lesions, stenosis is by far the most dangerous. Acute endocarditis has, during pregnancy, a marked tendency to assume the ulcerated form; pericarditis is not perceptibly affected; the majority of women with valvular disease pass through pregnancy without serious harm, though they usually suffer extreme discomfort." And elsewhere the same author

says: "If a normal heart is auscultated during a strong labor pain, it is usually found that the increased arterial pressure, which is caused by the sudden arrest of the enormously developed uterine circulation during the pains, produces murmurs with one or the other heart-sound, which cannot be distinguished from those which are the result of valvular disease. In view of this fact, it would seem *à priori*, that a heart which was the seat of serious valvular disease could hardly be expected to preserve its activity under so severe a test. *In point of fact, valvular lesions cause extreme suffering from dyspnea during labor. But, in the majority of cases, produce no worse result.*"

In the meeting of the Obstetrical and Gynæcological Society of Paris, February, 1892, during an incidental discussion of this subject, Guéniot, L. Championnière, Pajot, and Dumontpallier, cited a number of experiences which made them believe, "That the association of cardiac affections with pregnancy did not import such a grave prognosis as was formerly believed to be the case." In a recent meeting of the American Obstetrical Society, held in this city, Dr. Snader expressed similar views. Osler seems also to hold such opinions in his *Practice of Medicine*.

After looking through my note-book I find but twelve cases of cardiac complications during pregnancy or labor recorded. Of these twelve, four died, five had premature confinements, and two aborted.

Of these four deaths, one occurred somewhere about the seventh month of pregnancy without delivery of the child, instigation of premature labor having been proposed but refused. The child died before its mother, who died before labor began. One died in labor, one some ten days after delivery and one ten hours after delivery, Three of the deaths occurred in multipara and one in a primipara.

In five of the nine cases who lived through the pregnancy, labor, and puerperal period, the labors were very hard, version being performed in one case and the forceps being used in the other four. An anæsthetic (the A. C. E. mixture) was used freely in every case. This anæsthetic, or ether alone, was used in three other cases, where it seemed advisable to quiet nervous excitement and pain, although the labors were not hard. I have not been able to follow up the after histories of all these patients, but in some two or three, I know that they have lived for several years since their pregnancies and are still alive. One I have attended in two confinements, who has a mitral insufficiency. I know of two cases, one of whom had a mitral stenosis and one of whom had a chronic endocarditis, who died a few months after their delivery.

In the majority of the cases I have advised against lactation, but in two of the cases and notably in the one referred to above as having undergone two pregnancies, this function was performed.

The case of the primapara who suffered from mitral stenosis, was interesting from the fact, that in the ninth month of her pregnancy she was attacked with puerperal convulsions, after having been apparently, perfectly healthy up to that time, that she had a number of very severe convulsions and successfully passed through these and through an artificial dilation of the cervix and prolonged use of an anæsthetic, and was finally delivered by the forceps. She returned to consciousness and was apparently doing very well for some five hours, when a rapid œdema of the lungs occurred from which she died.

As œdema of the lungs is such a frequent result of puerperal convulsions, it would seem in this case as though the cardiac trouble aggravated, but was not necessarily the cause of the œdema, and it seems astonishing to think that a woman could live through the severe strain of succeeding convulsions, of a prolonged anæsthesia and of a forceps delivery with such a serious cardiac lesion.

From such a diversity of opinions there must result a great confusion and doubt in the mind of a student, who has not had sufficient variety of experience on which to build up some foundation for an individual opinion, and I have thought that the subject would be an interesting one to bring before the society, that discussion may furnish statistics which may prove to be of value.

From my own experience which shows a mortality of $33\frac{1}{3}$ per cent. during pregnancy, labor or the puerperal period, I cannot but feel as though I must echo the opinion of those who consider the prognosis as very grave, and I am therefore always inclined to advise patients who are sufferers from some valvular lesion not to marry, and if married to avoid child-bearing. And my opinion is founded not alone on my own statistics, but also on those of others referred to already in this paper.

Furthermore, it seems to me to be borne out by a careful study of the changes in the circulation and in the circulatory apparatus, which results from pregnancy.

It has always seemed to me to be a peculiarly interesting fact, how in the pregnant state, there results a condition, which can well be considered as bordering closely upon a diseased state, and how, the pregnant woman while simply fulfilling one of her functions is yet brought to such a state, that she hovers as it were between health

and disease; and not only is this a valuable point to remember in considering the subject of this paper, for it is, as I believe, of the utmost importance as explaining the aetiology of many of the diseases which occur in pregnancy. The marked increase in the quantity of the blood through the increase in the watery portion, the increase in the quantity of fibrin, and the decrease in the relative number of red blood corpuscles, of albumin and of iron, present a condition of things so simulating that of disease that it is hard to realize that it is the physiological result of pregnancy, for the hydræmic pregnant woman approaches so closely upon a state of anæmia, that a true and pernicious anæmia may occur so easily and so stealthily that it may escape notice for a long time and only finally the condition be differentiated from that normal to pregnancy by the discovery that a disease of some of the organs has resulted.

If now we consider that owing to the increased amount of work given to the heart by the increased quantity of blood and the increased size of bloodvessels, that an hypertrophy of the left side of the heart results, we still more closely approach to the abnormal, and while I recognize all these changes as physiological when the heart is normal, I cannot also but realize how such changes may interfere with compensatory actions in the heart, and I therefore present the question for discussion, hoping that those gentlemen who consider cardiac complications as influencing pregnancy and labor but slightly may give me information and statistics which may relieve my mind from the anxiety which now oppresses it when I am forced to encounter such a condition.

THE OCCASIONAL DEPENDENCE OF UNUSUAL SYMPTOMS UPON THE PRESENCE OF HEART DISEASE.

BY EDWARD R. SNADER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
September 14, 1892.)

EVERY practical physician is aware that the text-book pictures of diseases are not often met with in their purity. Of necessity, in dealing logically with given diseases the text-books must consider typical cases, and can only, in very rare instances, take in the unusual complications that may arise from pre-existing diseases, or from diseases almost directly opposite in their nature. In other

words, the text-book cannot take cognizance, in the consideration of a single disease or group of diseases, of the entire man, with all his previous diseases, predisposition and hereditary tendencies and other less obvious conditions. Every practical physician knows, too, that he must occasionally abandon the beaten paths of diagnosis and depend upon his knowledge of physiology and anatomy and pathological changes to diagnose certain cases. He can sometimes diagnose a case correctly, and yet cannot name it; cannot place it in a definite, specific category of known, named disease. In other words, he can tell that a certain condition is present, which gives rise to the symptoms of which the patient complains, and yet cannot call the disease by a specific title.

These general remarks are perhaps explanatory of the intention of my paper, which is to consider rather briefly, and simply in a suggestive way, the possibility of the dependence of unlooked-for and unusual symptoms upon the presence of cardiac disease, organic and functional. We all know the groups of symptoms connected with typical cases of cardiac disease. These observations, of course, do not apply to cases of perfectly compensated valvular diseases.

Regarding the last-named affections, it is a matter of personal experience with me that many of the classical symptoms indicative of a rupture of the compensation are not observable in many cases in which an actual, although not decided, rupture of the compensation has occurred. Of the frequency of unsuspected valvular lesions I need not here refer. Some of the cases I shall cite will show that, in a general way the possibility of the existence of heart disease would not be suspected. I shall not consider the heart from the standpoint of a specialist, but from the standpoint of a general practitioner.

I hold, and have always held, that the knowledge of the actual condition of organs obtainable by means of physical diagnosis should be the possession of every man practicing any specialty in medicine. Possibly, however, the fact that I devote considerable time to the careful and systematic study of cardiac diseases has led me to a solution of some problems in diagnosis, and consequently to some results therapeutically, that I might not have obtained had I not been perfectly familiar with the technique of physical exploration.

Let me cite a few cases of unusual symptoms dependent upon the existence of cardiac disease.

CASE I.—Young lady, æt. 27. Had suffered for about eight years at every menstrual period with an exhausting diarrhœa; the

diarrhœa was so exhausting that she had scarcely recovered from the effects of it until another period of functional ovarian activity was upon her. She was weak, emaciated, worn, neurasthenic, and, to use her own words "a perfect wreck." The menstrual diarrhœa had continued unabated, recurring at regular intervals, despite the constant attention of excellent physicians of both schools. The amelioration following the administration of remedies was exceedingly ephemeral. In point of fact, it may be said that, practically, they were absolutely inefficient. The diarrhœa was somewhat serous in character. Her physician, believing that her trouble was dependent in a measure upon some local disorder of the uterine functions, made an examination under ether and discovered endometritis and a retroversion of the uterus. Replacement was made, and it was presumed that now she would make a recovery. The uterus was replaced and the endometritis treated locally for some time with but an extremely slight change in the symptoms, certainly not enough change to warrant the idea that the true cause of the diarrhœa had been discovered. During some later attacks of diarrhœa, symptoms almost collapsic in character appeared, and I was summoned in consultation. Inasmuch as the menses were decidedly profuse and long lasting and the other symptoms gave evidence of vascular excitement, I conceived the idea that violent congestion was at the bottom of her profuse menses and of her diarrhœa. But why the congestion? Searching for a cause, after a careful examination, I discovered she had a catarrhal enteritis, slight enlargement of the liver and a mitral regurgitation. My theory was that, owing to the presence of the mitral regurgitation the congestion of the liver and enteritis resulted secondarily, and with the normal afflux of blood to the genital organs at the time of menstrual period, the veins were surcharged with blood, alterations in vessel tension took place, and the result was this distressing serous diarrhœa. Acting upon this hint, and knowing that all known diarrhœic remedies had failed, administered both antipathically and homœopathically, I placed her upon a cardiac tonic, with immediate and almost marvellous relief. At the following menstrual period the symptoms were decidedly improved. The case is still under observation. I have not the slightest doubt but that a cure will result.

Another case of menstrual diarrhœa, occurring in a young girl of 17, of whose genitals no examination was made, also recovered under a cardiac tonic. She had mitral stenosis and regurgitation.

CASE II.—Lady, æt. 52. Had for more than two years been

troubled with an exceedingly distressing dysuria. She was compelled to attempt the passage of urine, particularly in the morning, about every half hour, and the burning and pain were something appalling. The urine was passed at times drop by drop. There was no retraction of one side of the vulva and no pain along the course of the ureters. She would have occasional intermissions for a few hours. At no time did she pass blood. A careful analysis of the urine disclosed nothing abnormal. The bladder was examined for stone, and the urethra searched carefully for evidences of the presence of irritable caruncle. A slight displacement of the uterus was found; but, not enough, in my opinion, to justify such violent dysuria. Along the vagina and particularly in the cul-de-sac of Douglas, little ecchymotic spots were discovered, resembling very much purpura. Finding no stone, no irritable caruncle, and no displacement sufficient to account for the symptoms, I was led to believe that the symptom was dependent upon capillary hæmorrhages and consequent pressure upon nerve filaments supplying the urethra. Hamamelis was injected into the bladder and given internally, and china and secale were also given internally without result. All the remedies homœopathically indicated also failed. In despair, I examined the woman from top to toe and found a slight enlargement of the liver and evidences of a catarrhal inflammation of the bowels, and also a mitral regurgitation and an aortic stenosis. There were no symptoms of failure in compensation. I then believed that I was dealing with a reflex pain—reflex from a catarrhal enteritis—and prescribed the indicated remedies, and failed to relieve the symptom. I then administered remedies based upon the hypothesis that the enteritis was secondary to the mitral regurgitation, and the enteritis immediately began to improve and with its subsidence the urethral distress gradually disappeared.

CASE III.—A young man, æt 22, came to me, complaining that he had some skin affection affecting the ends of the fingers of both hands. An examination disclosed that the skin was shrivelled, numb and slightly scaly, a white epidermal scale. Save an acne vulgaris, he had no skin affection. I did not believe the disorder to be Renaud's disease, and began a systematic examination of the man. I found a slight chronic bronchitis, an enlarged heart and a mitral stenosis and regurgitation. I believed the supposed skin disorder and the bronchitis were both dependent upon a slight rupture of the compensation, and medicines directed to the heart soon secured a relief of the scaliness and a disappearance of the shrivelled appearance of the fingers, and the bronchitis decidedly improved.

CASE IV.—An old lady, æt. 83. I was summoned to attend her for symptoms indicating inflammatory entero-colitis. She apparently did not make proper progress, and at my third visit, to my horror, displayed a decided lead-colored tongue. Recalling, very distinctly indeed, the unfavorable prognostic significance attached to this lead-colored omen, I was on the point of giving a very unfavorable prognosis when my attention was attracted to the unusual number of respirations per minute. They were entirely disproportionate to the amount of fever. An exploration of the lungs proved negative. An examination of the heart disclosed a condition of general atheroma; murmurs were present at all the orifices. I then considered that the lead-colored tongue was due to an intense degree of venous congestion. I alternated the iodide of arsenic with the indicated remedy. At my next visit the patient was decidedly better, and the lead-colored tongue had nearly disappeared.

CASE V.—Man, æt. 35. Sent to me from Knoxville, Tennessee, to determine the amount of lung solidification present. He was a sufferer from phthisis, and had apparently gotten along fairly well for the last six or seven years. In the course of conversation during the examination I learned that when hæmorrhages occurred they were unusually copious and extremely difficult to control. The ordinary remedies seemed to be inefficient. His family and personal history gave no warrant to the assumption that he was a “bleeder.” Taking into consideration the chronicity of his case, I attempted to find a cause for the severity of the hæmorrhages and their long continuance. After an elaborate search of nearly half an hour, and a careful study of all the sound elements of the heart, I made a diagnosis of mitral regurgitation. I then found that many of the symptoms were readily explained upon the theory of defective circulation. I could now understand why his hæmorrhages were severe and prolonged. The back-wash of blood kept up a constant congestion of the lungs, and when a rent took place, by reason of pressure, prevented the formation of a clot until the accumulation of an enormous quantity of blood in the tissues overbalanced the lesser tension and increased the pressure to such an extent that it was possible for sufficient stasis to occur to produce a clot. I recommended that the ordinary medicines be abandoned in the treatment of his hæmorrhages and that digitalis be substituted. About a month later I was telegraphed to to send a remedy for hæmorrhage. Mr. J. had been bleeding for three days and nothing seemed to stop it. I answered, “Give him digitalis.” His physician subsequently wrote

me that the digitalis controlled the hæmorrhage, but that Mr. J. had an attack of pneumonia following it. Pneumonia, so called, was the direct result, to my mind, of the immense amount of blood coagulated in the lung tissues. I have seen four such pneumonias follow excessive hæmorrhages from the lungs, and in all cases have found present some valvular lesion of the heart. Mr. J. subsequently recovered from pneumonia, had several hæmorrhages, but they were always readily and rapidly controlled by digitalis.

CASE VI.—An old lady, æt. 82. Troubled with absolute anorexia. She had no desire for any kind of food. A few teaspoonfuls of some liquid food was all she could be forced to take. She was weak and emaciated. Her skin was decidedly muddy. She complained of vomiting after the least food, the vomited matter consisting sometimes of bile, sometimes of mucus, and occasionally seemed to be simply of water mixed with dark blood. No symptom, however, bothered her so much as the absolute disgust for food. She had been unsuccessfully treated by old school as well as new school practitioners. The changes had been rung upon all kinds of prepared food; pepsin, pancreatin, papoid and all the digestive agents had been tried in vain. Foods had been given from Valentine's meat juice down to the baby foods and up to koumysgen. In spite of all, while there was cessation of vomiting to a certain extent, the absolute anorexia still continued, and she was growing weaker and weaker. Upon being summoned to the case, I realized that a difficult task lay before me, and believed that I must find the cause of the anorexia before I could hope for a successful solution of the question of treatment. An examination of the abdominal region disclosed tenderness throughout, more marked over the epigastrium. The liver was exceedingly small and the spleen slightly enlarged. The lungs showed senile atrophy and a general chronic bronchitis. She breathed with a decidedly stridulous inspiration, and there was present atheroma of the heart and of the vessels throughout the body. There was also a very decided mitral regurgitant murmur, which I imagined, from the history of the case, was the result of a previous attack of rheumatic endocarditis. Slight albuminuria was present, and the passages from the bowels were sometimes light colored for a long period, covered with mucus, but occasionally were exceedingly dark. A diagnosis of mitral regurgitation, general and cardiac atheroma, atrophy of the liver and passive congestion of the kidneys were made, together with a gastro-enteric catarrh. In the general atheroma and mitral regurgitation

I found a solution, as I imagined, of the presence of the anorexia. Owing to the insufficient blood supply to the liver and the stomach, no proper stimulation of those organs occurred, nor were they in a fit condition to carry on the functions pertaining to nutrition. Absolute anorexia was nature's method of expressing her inability to properly handle food. All therapeutic measures had failed to do anything but produce the slightest amelioration until cardiac tonics were employed. Digitalis improved her very slightly; strychnia did more for her; but cactus was of more service than any other medicine. The period of her treatment occupied some three or four months. She is now taking some little solid and plenty of liquid food with a fair relish, is able to be up and about, and is cheerful and happy. The bronchitis has entirely disappeared. The stridulous sound in the inspiration is gone, and she has lost a little hacking cough and asthmatic breathing to which she had not been a stranger for years.

CASE VII.—Lady, æt. 42. Complained of weakness and hæmaturia which had existed for some three years. The blood in the urine was especially noticeable at the time of the menstrual period. Frequent urinary examinations disclosed the presence of blood, a slight degree of albumin, but no epithelial or hyaline casts. The quantity of urine was normal and the specific gravity raised only slightly. Examinations of the urine at the time when there was no hæmaturia occasionally showed very delicate traces of albumin. There was no history of malaria. Believing some circulatory trouble was at the bottom of the hæmaturia occurring on or about the menstrual period, I made an examination of her heart and found a mitral regurgitant murmur. She was dieted and placed upon a cardiac tonic. Two subsequent menstrual periods were passed without the occurrence of hæmaturia. The case is still under treatment.

CASE VIII.—A man, æt. 35. Complained of sudden attacks of nausea. His digestion was perfect, tongue clean, bowels regular, and he had absolutely no symptoms indicating any disorder of the digestive apparatus. The attacks sometimes followed exertion and sometimes not. A mitral stenosis and regurgitation were discovered and the diagnosis of secondary congestion of the stomach was made. Iodide of arsenic cured.

I could go on citing numbers of cases of peculiar forms of vertigo, of unusual skin symptoms, of menstrual anomalies and of extraordinary disturbances in the vasomotor system that were directly and indirectly traceable to functional and organic heart disease, to

prove the importance of the necessity of investigating the heart in many cases of disease.

I am not, I trust, one of those who sees all diseases through the spectacles furnished by his own specialty. I cite these cases in order to urge upon the general profession the necessity of careful general examinations of many organs in order to determine, if possible, the origin of peculiar symptoms or of usual symptoms that do not yield to ordinary therapeutics.

A STUDY OF CERTAIN DRUGS CAUSING CYANOSIS.

BY EDWARD CRANCH, M.D., ERIE, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
September 14, 1892.)

WHAT, in the first place, do we mean by cyanosis? Dunglison calls it "a disease in which the surface of the body is colored blue" from patency of the *foramen ovale*, or some obstruction of circulation in right side of heart, but Foster gives a better definition, namely, "a bluish discoloration from defective æration of the blood." The word is from the Greek *κύανος*, blue; and the condition is a familiar one occurring in collapse, asphyxia, and cardiac failure. The mental state may be one of hebetude or anguish, the surface warm or cold, moist or dry, and the muscles relaxed or in spasms.

It is alarming always, but notably so when extreme cardiac and pulmonic failure, as in artificial anæsthesia, in advanced pneumonia, in croup, in pleurisy and in cholera.

It is of lesser import, and causes less alarm, in ague, in congenital diseases of the heart, and in chronic asthma, because in these complaints a certain tolerance is established, and the blueness does not increase beyond a certain point. Cyanosis of the tongue is more alarming than elsewhere, because the bloodvessels of the tongue are so closely related to the vascular system of the brain, especially from the under surface of the tongue, by which important information may often be secured.

Please observe that cyanosis means more than simply pallor, or a hippocratic expression of features; it always means blueness or duski-ness, in accordance with its use in the original Greek.

Now on comparing the lists in the repertories, with the list of drugs known to have caused cyanosis, we find that several put prominently forward, are not known to have caused this condition

which they have removed. This does not prove that they could not have caused it, only that observations are still lacking.

Foremost of those causing it, is aniline, whose presence may often be detected by this very symptom, as when phenacetine, anti-febrin, or some of their kindred, have been administered, and the chemistry of the stomach has evolved the poisonous ingredient. Yet in one of the records (*Chemist and Druggist*, May 31, 1890), we find these words, "the characteristic blueness of skin was general over the whole surface, but especially dark on eyelids, chin, and temporal region;" then it says "the general appearance was quite different from that of cyanosis." It would be interesting to hear that writer's definition of cyanosis, if the aforesaid condition differed from it, but probably he, or she, meant to say that the collapse was not so thorough or profound, as is usual in cases that exhibit that degree of cyanosis.

With the blueness of aniline poisoning is associated more or less gasping for breath, a small and irregular pulse; dulness of sense, slight or no convulsions, or contractions of limbs, sometimes vomiting and severe diarrhœa, sweating and partial collapse, with feeble voice. A peculiar symptom is anæsthesia of arch of palate, so that tickling fails to excite nausea. Urine deep-brown, great weakness and loss of appetite. Tensibility generally retained, coma only late.

Next to aniline, in the frequency and severity of the cyanosis, is nitro-benzine, or artificial oil of bitter almonds, which produces also trismus and other tetanic symptoms, with slow respiration, and unconsciousness. Another drug is nitrite of soda, the cyanosis from which is very marked, especially about lips, with giddiness, strong beating of heart, swollen feeling of face and head, and symptoms of collapse, with nausea, and vomiting. None of the above drugs have been proven with care or interest, so far as known, and verifications are lacking, but for cyanosis as a prominent symptom, with great debility, and few other symptoms, they should be of use. The natural oil of bitter almonds causes cyanosis, with a very prominent brilliancy or glassiness of the eyes, which yet have a vacancy of expression, or a complete unconsciousness.

Hydrocyanic or prussic acid, the active principle of the above, and of several other drugs, laurocerasus, kalmia, etc., gets its name, not from its power of causing cyanosis, as it does, but from its chemical action in forming Prussian blue, a ferric ferro-cyanide of potassium.

In aniline, Prussic acid, copper, and baptisia, we have a group that seems to illustrate the old doctrine of signatures, or blues curing

blues. It is not by reason of their blueness, however, that they cause or cure blueness, but by their depressing action on the heart, for aniline and copper form many colors beside blue, and other substances, not blue at all, will cause blueness or cyanosis.

Copper-poisoning is extremely painful, and highly spasmodic, and only blue in its extreme stages, with partial or complete relaxation, and unconsciousness; and baptisia causes blueness from congestion of the face and head, with fever and delirium, but rarely complete unconsciousness.

Arsenic causes cyanotic symptoms by engorgement of veins, which show hard, full, and knotted, not totally relaxed as from the aniline poisons.

Snake poisons, especially the bothrops, will produce cyanosis, but more often a yellowness. Bothrops causes amaurosis and day-blindness with sciatica, hæmaturia, pulmonary congestions, and paralysis beginning in extremities, with capillary hæmorrhages from slight causes, with refusal of blood to clot, as in crotalus. A recent case of nose-bleed, in a constitutional bleeder, was promptly and permanently controlled by crotalus 30. There was blueness under the eyes from extravasated blood, and a general nervousness. Lachesis causes more of a localized cyanosis, as a round ulcer, eruptions, and wounds, also, blueness of the tongue.

In the action of the snake poisons, pain is not prominent, but hyperæsthesia and anæsthesia are common. Convulsions and collapse are rare, except just before death, if that occur.

Colchicum is one of the painful producers of cyanotic symptoms, and, as Dr. Lee has remarked, is closely related to the phenomena of cholera. The blueness is not very characteristic, and is mostly confined to the face—cheeks, lips, and eyelids.

Carbonous oxide, found in coal-gas, and sometimes as an outsider in laughing-gas, causes blueness of the conjunctiva, noises in the ears, trismus, nausea, and anæsthesia of the skin. Heat is a good antidote, as it also is for the over-action of chloral, chloroform, and ether, which are familiar producers of cyanosis, often speedily followed by complete asphyxia and death.

Opium cyanosis is not so alarming, since it is generally noticed while the body is still very warm, and often passes off spontaneously, like the cyanosis of alcoholismus.

Nux vomica and strychnia cause blueness by their tetanic action, associated with pain, and generally full consciousness.

Glonoine cyanosis is preceded by pain, but rapidly followed by unconsciousness, and is most exactly allied to apoplectic coma.

Aloes produces a somewhat similar state, but with less unconsciousness.

Sulphur causes duskiness, with faintness and exhaustion, and is of service in chronic blue conditions, along with lachesis, arsenic, digitalis, cactus, tartar emetic, and others.

Digitalis has no recorded case of cyanosis caused, but a large record of cures.

Carbo vegetabilis and camphor have not often caused it, but have very often cured it, with anxiety, coldness and rigidity.

Veratrum album and nicotine may be thought of here, with a great usefulness in cholera, but, with cyanosis proper, not a prominent symptom; generally, only a duskiness under the eyes.

Copperas is closely related to veratrum, but may be distinguished by green vomit, with copper, and stronger voice with veratrum, and more complete suppression of urine with copper.

Ailanthus belongs in dusky fevers, with great prostration, as in scarlatina, la grippe, and diphtheria.

Ranunculus bulbosus in blueness of eruptions; argentum nitricum in the blueness of malaria and of diphtheria, along with baptisia and lachesis.

Bromide of potash has a mottled blue, sometimes found in apoplexy, and in "worm-spasms" of children.

Hamamelis has a passive, local blueness, not very alarming, but often characteristic, as in all forms of varicosis, where it is ably complemented by lycopodium.

Secale, phosphorus, arnica, and sulphuric acid, have the blueness that belongs to ecchymosis.

Pulsatilla and crotales are of more use in dark-colored erysipelas; veratrum viride in congestive fevers; bromium in croup—all with cyanosis.

Berberis and china have a general blueness, associated with engorgement of the portal circulation; the blueness of berberis showing more inside the lips, that of china more about the sockets of the eyes.

Plumbum, when it produces blueness, has a notably dry skin, continuous pain, or else unconsciousness.

Tartar emetic, on the contrary, has profuse sweat, and is free in all secretions, unless in that of the urine.

Other remedies, of course, produce and cure cyanosis; but it is believed that these are the chief of the cyanotic group of drugs. Verifications can doubtless be furnished by all of you from your own experience.

A PROVING OF PLUMBUM.

BY F. P. MCKINSTRY, WASHINGTON, NEW JERSEY.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, September 14, 1892.)

A PAINTER while at work was taken with severe pain in the abdomen which from the history and subsequent symptoms was evidently an attack of "painter's colic."

Several days later I was called and found the case presenting the following symptoms: Great prostration; marked nausea; oppression of breathing; waxy, pallid appearance of face; frequent urination, without pain and the quantity of urine greatly increased.

The urine was of low specific gravity and by analysis yielded considerable albumin. The constipation, slimy tongue, sickening odor of the breath and the blue appearance of the alveolar margin of the gums stamped the case as one of lead absorption.

In passing, I will state that the patient regained his health in a few weeks, gave up his trade and remained well until his death which resulted from accident a few years ago.

This case was treated several years since and I am sorry that I do not have a complete record of the analysis of the urine, but enough symptoms have been detailed to suggest the similarity of the effects of lead poisoning to Bright's disease especially the contracted or granular form.

That this is not an infrequent or accidental result of the absorption of lead a mere glance at our materia medica will show. One of the finest illustrations is the case of a painter who died from lead poisoning, quoted by Allen in his *Encyclopædia of Materia Medica*.

"The clinical history showed polyuria, albumin and convulsions, no anasarca. Under the microscope the kidneys presented an exquisite picture of interstitial nephritis in an early stage.

The cortical substances especially presented great cellular hyperplasia and increase of interstitial connective tissue.

The glomeruli presented varying characters, some normal others atrophied to fibrilla knots of connective tissue, and others in all possible stages of degeneration."

These are a few of the many suggestive symptoms given.

In the *Cyclopædia of Drug Pathogenesis*, we may read under plumbum a perfect description of interstitial nephritis, including the ear-

diac changes, the ocular lesions and uræmic convulsions. We have space for but two brief extracts.

On page 661 we read of a man who had been a painter for forty years and who died in a Paris hospital of lead poisoning. The urine had showed casts and albumin, and the autopsy found the kidneys notably diminished in size, numerous granulations on surface, color yellowish, the cortical substance opaque. Microscopic examination showed the alterations present in Bright's disease arrived at the stage of atrophy of the cortical substance.

On page 662 is an account of a painter who had followed his trade for thirty-five years but was forced to quit work owing to palpitation and oppressed breathing. Urine pale, specific gravity 1010°; contained albumin and hyaline casts. After repeated convulsions he died comatose.

The autopsy showed kidneys reduced to one-half normal size, granular and affected by interstitial nephritis.

Dickenson, an English authority, states that the records of St. George's Hospital kept by him for seven years, showed that forty-two workmen having to do with lead as painters, plumbers, etc., died from disease or accident and were examined at the hospital. Of this number, twenty-six had distinct *granular* degeneration of the kidneys.

This review of the pathogenesis of lead is given to emphasize its homœopathic relation to the common and fatal granular form of Bright's disease.

A number of cures have been reported by competent observers. Dr. Charles Gatchell says: "In 1876 I made a cure in an undoubted case of incipient renal cirrhosis, using plumb. met. 6x trit. alone. In numerous other cases which however were already chronic when coming under treatment, by the same remedy the disease has invariably been arrested in its rapid course with improvement of all symptoms for a time."

The doctor also reports a case cured in 1883 in Cook County Hospital, Chicago.

Dr. S. A. Jones reports a case of cirrhosis of the kidneys of three years' duration. After using plumbum he was able to resume and continue work for one year after, and lived three years.

Mitchell, in his work says: "Plumbum is the standby in this disorder if not due to lead poisoning or syphilis."

Even in Ringer we find a hint of this therapeutic fact.

We read that "Lead has been found to *diminish* the secretion of

albumin in the urine and to increase the quantity of urine." Then follows this startling statement: "Neither the diminution of the albumin or the increase of the urine appeared to hold any relation to the *quantity* of lead administered."

Millard, another orthodox in good and *regular* standing, says in his work on Bright's disease: "It is possible that this mineral which has such a poisonous effect upon the kidneys, may yet be found to possess curative properties in affections of them."

I have prescribed lead in several cases but have no cures to report. One case which suffered much with a constrictive pain in the abdomen was greatly relieved during its administration but finally succumbed to the disease.

An early diagnosis is essential to curative treatment, and we would discover incipient cases more frequently if we formed the habit of careful urinary analysis with special reference to the specific gravity and the excretion of urea.

Since the introduction of Parke, Davis & Co's ureometer it is possible for the general practitioner to make a quantitative urinalysis and discover the exact amount of urea excreted daily, which in the disease under consideration is more important than the presence or absence of albumin.

AMOS RUSSELL THOMAS, M.D.

AMOS RUSSELL THOMAS, M.D., author, physician, and Dean of the Hahnemann Medical College, of Philadelphia, was born in Watertown, New York, October 3, 1826. Dr. Thomas is descended from a solid ancestry of Welsh descent. The family came to New England over two hundred years ago, and were among the earliest settlers in Boston, Newton, Hardwick and New Salem. From this New England branch of the family sprang many who have been distinguished in the professions, in the army, and in various walks of life. Hardy, long-lived and prolific, the family has become exceedingly numerous, and widely scattered throughout the United States. Of the fifteen children of the great grandfather of Dr. Thomas, thirteen lived to marry and rear large families. The average age of the thirteen was seventy-two years; the combined age was nine hundred and thirty-six years. Dr. Thomas is the son of Colonel Azariah Thomas, who served under General Jacob Brown, on the Northern frontier, in the war of 1812.

Thrown upon his own resources at an early age, the subject of this memoir acquired his education, both literary and professional, by his unaided individual efforts. His life was passed in the country until he was nearly twenty years of age, and by manual labor upon a farm he acquired a robust and vigorous physical constitution. Dr. Thomas's early evinced love for books led him to devote his evenings and other intervals of leisure to study, and in this manner he qualified himself and commenced teaching school in the western part of New York in 1846.

Four years after, in 1850, he engaged in mercantile pursuits in Ogdensburg, New York, but finding this employment an uncongenial one, he turned again to his books and resolved to devote his future to a professional pursuit. By getting possession of an old Indian skull, which had been exhumed in making an excavation near his place of business, and borrowing a work on anatomy, for the purpose of studying this skull, he became so much interested as to engage at once in the study of medicine. He entered the Syracuse Medical College in 1852, devoting himself assiduously to the study of his chosen profession, and was graduated in February, 1854. Upon receiving his degree Dr. Thomas repaired to Philadelphia, and, after attending a course of lectures, he again graduated from the Pennsylvania Medical University. His abilities had long since met recognition, and, upon his graduation at this institute he was immediately offered the position of Demonstrator of Anatomy by this medical school, which he accepted, and made Philadelphia his home. In 1856 he was appointed to the chair of anatomy, which position he filled for ten years. In the same year also he was appointed professor of Artistic Anatomy in the Pennsylvania Academy of the Fine Arts, where he delivered annual courses of lectures to artists and art students for fifteen years. These lectures were the first of the kind ever given to art students in America. In 1863 he was appointed lecturer on the same subject in the School of Design for Women, which position he held for ten years. After the second battle of Bull Run, during the war of the Rebellion, he volunteered his services as surgeon and was assigned a position in the Armory Square Hospital, at Washington, where he remained in charge of one of the wards until the wounded from that disastrous field were cared for. He then returned to Philadelphia and resumed his practice, which has always been both lucrative and select.

Becoming interested in an examination of the merits of Homœopathy soon after settling in Philadelphia, he was finally led to

adopt that system of practice. In 1867 he was called to the chair of anatomy in the Hahnemann Medical College, of Philadelphia, and in 1874 was elected Dean, which position he still holds. As a lecturer on anatomy Dr. Thomas has acquired a reputation for clearness and accuracy, and for an impressive manner, which at once attracts and retains the close attention of the student. The institution at whose head he presides is one of the strongest and highest in rank among Homœopathic medical colleges of the country. During his administration as Dean, and largely from his personal influence, the college has advanced its curriculum of study, elevated its standard, secured its new building (which is in all respects equal to the best in the country), and entered upon a career of success never before attained.

In addition to attending to a large professional business, Dr. Thomas has found time to contribute a number of important papers to medical journals, besides writing a work on *Post-Mortem Examination and Morbid Anatomy*, which has been highly commended by the medical press, and for five years to act as general editor of the *American Journal of Homœopathic Materia Medica*. He has had two children,—a son, Charles M. Thomas, M.D., of this city, and a daughter, who died in 1880, wife of Dr. J. N. Mitchell, leaving one child, a son.

Besides the County and State Medical Societies, of which he has been President, Dr. Thomas is a member of the American Institute of Homœopathy, of the Academy of the Natural Sciences, of the Fairmount Park Art Association, of the Pennsylvania Horticultural Society, and of the Historical Society of Pennsylvania.

LOCATION OF TUBAL ABSCESS AS AN INDICATION FOR ITS TREATMENT.—If near the uterine end of the tube, by all means try dilatation and packing of the uterus; follow with intra-uterine antiseptic irrigation always before subjecting our patient to laparotomy. Thoroughly irrigate the vagina with bichloride solution $\frac{1}{3000}$ and carefully pack the uterus with strips of iodoform gauze, packing the side nearest the abscess tighter than elsewhere, and leave one inch of the ends of these strips hanging out of the cervix. Now pack the vagina with gauze to its outlet. The patient should now be put to bed and given an hypodermic injection of morphine. The gauze should be removed in twenty-four or thirty-six hours, when pus will be found issuing from the uterus, the gauze being saturated. After removal of the gauze wash the uterus out with bichloride solution, $\frac{1}{3000}$, and pack as before but not so tightly. If pelvic cellular abscess be on either side of the uterus, enclosed by the intestinal adhesions or ovarian abscess, or involving the tube near its outer or abdominal end, then abdominal section must be practiced.—Walter B. Dorsett, M.D., in *The American Journal of Obstetrics*, August, 1892.

EDITORIAL.

CHOLERA.

CHOLERA is knocking loudly at our door for admission, having taken the route favored by tourists, selecting, naturally, steerage accommodation. Being an unwelcome intruder by way of the sea, our quarantine service should be, and apparently is, capable of absolutely controlling the importation of its pathogenic germ. And our health authorities are bending their best efforts to prepare a soil that will be uncongenial to its reproduction and diffusion. On these two factors hang the solution of a problem that is awaited with bated breath and intense anxiety by all who realize the seriousness of an epidemic of Asiatic cholera.

If our quarantine establishments are inadequate, or if their administration is incompetent, cholera will pass the barrier, causing untold loss of life and wealth to the nation, dependent solely upon palpable and censurable neglect. The source of greatest danger in the present epidemic is in the incessant stream of immigrants, with their filthy habits and belongings, that is dumped upon our shores from the northern ports of Europe. The suppression of this traffic would immediately place us in practical safety; the life and sanitary surroundings of cabin passengers is not calculated to produce cholera-breeding. The attempt of the President to suspend immigration by means of an enforced twenty-one days' quarantine, while unfortunately embarrassing and severe upon cabin passengers now afloat on their homeward trip, is the only sure and effective method of accomplishing the safety of the nation at a minimum cost to life and business wealth. The danger to America is in immigration, and the move of the national authorities calls for commendation rather than captious criticism. The fact that we have, as yet, no cholera cases beyond the limits of New York Bay is reassuring; that we may, and probably will, escape the pestilence for at least the present season; yet by no means should there be the slightest relaxation in the effort of the quarantine and health authorities to rid filthy districts of their insanitary conditions. Cholera itself is not so much to be feared as is the filth that may serve as a breeding-ground for the infection. There is a seemingly prevalent impression on the part of the public that safety to the general health of the commonwealth is assured with the oncome of first frost. If this will quiet a sense of suppressed fear and anxiety without relaxing vigilant preparation to prevent the establishment and diffusion of the cholera

germ, well and good. If, on the other hand, our authorities are going to allow the foreign element, which huddles together at the great centres of our population, to return to their natural squalor and filth, it will be well to recall that cholera, in the epidemic of 1831, did not appear in Edinburgh and Glasgow until January, nor in London until February, and in Dublin and Paris till March; while in 1849, Memphis and St. Louis, the cities first attacked in America, were not visited until January.

Patients should be counseled with in regard to unreasonable fear. If the advent of this disease will lead them to review the method of their living and result in the correction of habits and indulgences tending to weaken the constitution, the effect will be beneficial, but, while we acknowledge that fear in itself never yet produced a case of Asiatic cholera, we do know that fear will derange digestion, and just in the ratio of disturbed alimentation will the patient's susceptibility to the action of the cholera germ be increased. With the laity understanding that they can live with a cholera case; handle it, even though there be abrasions of their skin; breathe the same air with it with impunity, provided they will use caution and never forget that cholera enters the stomach only, and affects directly the intestinal tract, and that with perfect cleanliness and disinfection cholera will not propagate, fear will give place to an intelligent recognition of the methods necessary to combat and crush out the disease. The vomit and dejecta of cholera patients are the primary source of the infectious principle, and it is in this line that individual effort is to be made to prevent the spread of the contagion. Anything coming in contact with the evacuated contents of the stomach or bowels is at once capable of conveying the infection of cholera, this being especially true of soiled linen and clothing, tainted hands, contaminated articles of food and drink, all of which are means for the transmission of infection. Pollution of the water supply of certain districts by the evacuations of the stomach or bowels of a cholera patient, is the usual cause of a sudden and widespread attack of the epidemic. The necessity of absolute disinfection and of faultless cleanliness of everything that could have possibly come in contact with the discharges of a cholera case is apparent. Drinking-water must certainly be free from all sources of contamination, and the proneness of dairymen to water their product suggests at once the urgency of boiling milk before its use, particularly by young children.

With precaution of this character, and knowing that on the whole the tendency of the individual to succumb to the disease is small,

especially if immediate attention is given to the oncome of any of the alimentary disturbances so prevalent at this season of the year, one can face the onslaught of an epidemic with the hopeful assurance of passing through it unscathed. In this connection it is refreshing to watch the course of England. Exposed to the invasion of the epidemic at any one of her innumerable ports of entry, and with cholera planted upon her soil by voyageurs at a dozen different points, she makes no effort or attempt to quarantine against the world and leave the hapless traveller to his fate; but depends, with a sublime faith, upon her excellent sanitary system to protect her and her vast interests by rendering her soil and her people an uncongenial harbor for the specific germ of cholera. For a systematic review of cholera, its history, its prophylaxis and its cure, we refer the reader to the able articles upon the subject by Drs. Fornias and Mohr, appearing in the current number.

NEITHER ORIGINAL OR NEW.

A CONTRIBUTOR of the *Brooklyn Medical Journal* for August, 1892, has become convinced that bichromate of potassium has some therapeutic virtues, and accordingly reports his experience with the drug. This experience strikes the editor of the *Medical News* so favorably that he makes an abstract of the article, and publishes the same in his issue for August 27th. Here is the abstract:

"Based upon an extended experience, Hunt recommends the employment of potassium bichromate as an expectorant, especially in catarrhal conditions of the respiratory mucous membranes. The remedy is best administered by rubbing up one grain with nine grains of sugar of milk, and adding the desired number of teaspoonfuls of water. A child a year old may be given from grain $\frac{1}{50}$ to gr. $\frac{1}{20}$, at intervals at first of ten or fifteen minutes, but subsequently less frequently."

It is very plain from the above that Dr. Hunt acquired his knowledge concerning the value of kali bichromicum in respiratory troubles from homœopathic literature. His readers can be saved a great deal of trouble, however, and secure better service, if instead of triturating the drug themselves as directed, they buy the 1x trituration from one of our old reliable pharmacies. The dose Dr. Hunt recommends is unnecessarily large, if not, in some instances at least, unsafe, for we have seen the same drug do incalculable good in higher triturations.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D.,

FRANK H. PRITCHARD, M.D., AND EDWARD M. GRAMM, M.D.

DIAGNOSIS OF PRIMARY ENDOTHELIAL CANCER OF THE PLEURA.—Professor A. Fraenkel, of Berlin, had an opportunity to observe a case of endothelial cancer of the pleura. On preliminary examination, an ordinary left-sided and serous pleuritis was thought to be present, but the examining physician was soon struck by the violence of the symptoms of oppression, and the pronounced character, in general, of the symptoms—they being, apparently, not in reasonable relation to the size of the exudate. A trial puncture was made, and the resultant fluid found to be intensely colored, and resembling venous blood in appearance. The writer thought of the possibility of tuberculosis. The liquid obtained at the second tapping contained a large number of fatty, polymorphous cells. From this the diagnosis was made. The necropsy, which was done somewhat later, revealed the following characteristic changes: In the pleura, there was a series of milk-like and confluent plaques, of various sizes; the lymphatics were swollen in their interior, but not caseously degenerated; no signs of tuberculosis were to be discovered; microscopic examination revealed the vessels of the surrounding tissues to be filled with cells from the cancer. This affection, which, with regard to malignancy, stands at the side of carcinoma, is especially characterized by stasis of the lymphatic current as well as by proliferation of the endothelium of these vessels. Hence, the writer proposes the name "pleural lymphangitis." With regard to the diagnosis, the author calls attention to the following characteristic points: 1. The large quantity of blood in the exudate and the rapidity with which it collects; 2, the cells of the exudate; 3, very rapid and incomprehensible oppression of breathing.—*Norsk Magazin for Laegevidenskaben*, No. 7, 1892.

THE TREATMENT OF GASTRIC DILATATIONS.—Professor Dreschfeld writes as follows on the treatment of dilatation of the stomach when it occurs in the course of gastric ulcer. Dilatation may be noticed when the ulcer is still active, or it may be a sequence of the ulcer, and due to the stenosis caused by the cicatrix of the healed ulcer. It is important that these two forms be distinguished, for whilst the dietetic and medicinal treatment is the same for both, the mechanical treatment by washing out the stomach, which may be recommended when the ulcer is quite healed, has its risks as long as the ulcer is active. As regards the quality of the food, the dietetic treatment will depend upon the condition of the gastric juice. When it contains free hydrochloric acid, and where therefore abnormal fermentations are slight, we may give, besides nitrogenous food, a proportionate amount of fat and hydrocarbons; where the hydrochloric acid is diminished or absent, and the vomited matter contains acetic or butyric acid, with large masses of torulæ or sarcinæ, there we have to depend largely upon nitrogenous diet. Here peptonized food becomes particularly useful. Liquids should, as much as possible, be limited in dilatation of the stomach, and we should only give small quantities at a time, and give it often. Nutritive enemata have to be resorted to. Medicinally, we rely on alkalies, bismuth and tincture of nux vomica, given some time after the administration of food, and pepsin immediately after food. If there be much flatulence and discomfort, carbolie acid, creasote, the hyposulphites or sulphocarbolates may be given. Washing out the stomach is one of the best remedies we have for the troublesome symptoms of gastric dilatation. Cautious and careful manipulation is, however, to be observed. Dreschfeld has used lavage lately. Lavage of the stomach should not be done oftener than once daily, and should not be continued too long. The application of electricity, using the faradic or constant current, may do good in cases of gastric dilatation.—*Manchester Medical Chronicle*, September, 1892.

DIETETIC TREATMENT OF TYPHOID FEVER.—Dr. Wallace Beatty publishes a paper on this subject. He tells us that experience has led him to believe: 1. That most cases of typhoid fever, if not all, are best treated by liquid food in limited quantity—at most three pints; this food being chiefly or entirely milk. 2. That by thus limiting the liquid food, diarrhoea, hæmorrhage, tympanites, sleeplessness, and delirium will be most easily controlled. 3. That errors in diet frequently cause a renewal of the illness, which in its clinical features is exactly what most writers on enteric fever would regard as a relapse. Dr. Beatty considers that milk is unquestionably the best and safest food, given dilute with a little soda water, lime water, or plain water. If there be diarrhoea it is best to give the milk boiled. If milk be vomited, or curds are passed by the stool, whey may be given advantageously; if whey be given, beef tea with the grounds, or beef juice, should be given along with the whey, to take the place of the albuminate casein. He considers beef tea to be a useful addition to the milk diet when the patient is unable to take a sufficient quantity. It seems also to act as a stimulant. Dr. Beatty objects to farinaceous food on two grounds—first because they cause flatulence, may increase the fever, and may cause a fresh outburst if given early in convalescence; second they are not needed when sufficient milk can be taken. He is doubtful if beaten up eggs are digested by enteric patients. In his opinion two or three pints of liquid nourishment in the twenty-four hours is ample food for adults; less, proportionately for children. Towards the end of the third week when the ulcers are formed, it is often well to lessen somewhat the quantity of food. Dr. Beatty is disinclined to sanction unlimited quantity of simple drinks, fearing that they cause abdominal discomfort and diarrhoea. Dr. Beatty's guides in considering the question of convalescence and for permitting a change of diet, are the presence or absence of spots, the temperature, the condition of the tongue, abdomen and stools, and the size of the spleen. When convalescence has begun, he thinks the safest way to change the diet is to increase very gradually the consistence of the food. At first for a few days, it is safer to increase the quantity of the milk; then to give milk thickened with corn flour or arrow-root; then after a few days a lightly boiled egg and plain biscuits; then bread; then fish, and on. He considers that laxity in diet cannot be allowed without risk in any case of enteric fever.—*Dublin Journal of Medical Science*, September, 1892.

TREATMENT OF EXCESSIVE SWEATING.—Excessive sweating is most troublesome in the feet, decomposition readily taking place and leading to maceration of the skin and ulceration. It is essential that there should be the most scrupulous cleanliness, and that not only of the feet but likewise of the stockings and boots. The feet should be washed both morning and evening, and, if necessary, several times a day; the socks or boots changed two or three times daily, and the latter well ventilated. It is quite sufficient to wash the feet with lukewarm-water, and afterwards rub with some astringent, as eau de Cologne. To prevent maceration of the epidermis by the excessive secretion, and the formation of painful fissures, inunction should be adopted, using salicyl-lanoline, 2 per cent., which should not decompose, and the soles of the feet covered with a fold of linen smeared with ointment. Especial care should be taken to lay it between the toes, as here, on account of friction, eczema intertrigo is apt to develop. A powder, such as salicylic acid with talc, may be used instead of ointment. This suffices for the majority of cases. Chromic acid, recently recommended, has been followed by symptoms of poisoning, and ought not to be employed. In obstinate cases, Hebra's ointment or 10 per cent. boric acid lanoline should be applied on soft linen and continued for fourteen days without washing. The thick epidermis peels off, and when the soft skin is exposed warm water may be used for the first time. Excessive sweating in the face, axillæ and hands is much more troublesome and uncertain of cure. The face should be washed with eau de Cologne and powdered, and the hands frequently cleansed with water, and then with alcohol or $\frac{1}{2}$ per cent. solution of tannin. Tight gloves are forbidden, and the use of roomy woollen ones recommended. The axillæ must be washed frequently with soap and water and astringent lotions. To prevent eczema, cotton-wool, covered with powder, should be placed in the arm-pits, and, according to Saultfield, the so-called "sweat-folds," used by ladies, while protecting the clothing from excessive secretion, require the use of pads of wool to absorb the sweat, which is only too apt to decompose.—*The Practitioner*, August, 1892.

CEREBRAL HÆMORRHAGE FROM CHRONIC LEAD POISONING.—Dr. Letienne reports the following very interesting case. A house painter, 58 years of age was

brought into the clinic in profound coma. He was not a drinker and had not suffered from any other disease. Four years before he had had attacks of lead colic and since then he had suffered from headache, occasional vomiting and vertigo. For two months back he had been obliged to interrupt his work, on account of a fall and his condition continued to become aggravated, with the addition of lumbar and abdominal pains, while his lower extremities became oedematous up to the knees. One day, while at work he was suddenly seized with a feeling of sickness, vomited suddenly and gradually lost consciousness, biting his tongue and vomiting fecal matter. On being transported to the hospital he was found with an earthy colored and swollen and pallid face. On being spoken to he answered only in monosyllables. Superficial contact would cause slight fibrillary contractions of the muscles of the trunk. There seemed to be a certain degree of hyperæsthesia of the whole abdominal region. The tendonous reflexes were exaggerated. The eyes presented no deviations yet there was a certain degree of nystagmus. The pupils were contracted down to a narrow point in both eyes, the corneal reflex was nearly obliterated. Respiration was accelerated, without any definite type. Auscultation revealed crepitant râles at the base of both lungs. The heart was enlarged and the apex beat was to be seen in the sixth intercostal space. Stethoscopic examination was negative. The urine was pale and albuminous, three grammes of albumin being found in every litre. Rectal temperature 37. The next day the patient seemed better. Venesection was performed and 150 grammes of pale blood were extracted, which coagulated at once. A few hours after the patient died. The necropsy revealed the base of the right lung congested and the left oedematous. The heart was rich in fat and the myocardium hard and sclerotic. The valves presented nothing worthy of note. The stomach, liver and intestines were apparently normal. The kidneys were atrophied, the pyramids being with difficulty distinguished from the remainder of the organ. Histological examination revealed a very advanced chronic nephritis. In the brain, along the interhemispheric fissure several Pachionian granulations were noticed. The surface of the convolutions was covered with opalescent meninges. The vessels of the base were rich in yellowish spots which, however, were not hard to the touch. The medulla, protuberance and cerebellum were seemingly normal. The aqueduct of Sylvius was full of blood. The substance of the right hemisphere was almost normal though the ventricles were filled with blood. The left hemisphere was the seat of a considerable hæmorrhage which had broken into the ventricles. The hæmorrhagic focus was situated in front of the thalamus opticus, destroying completely the caudate nucleus, impinging on the anterior part of the internal capsule and the extra ventricular node. The zone of the frontal lobes was uninjured but the white substance of the corresponding lobe was entirely disintegrated in its median portion. At this point the apoplectic focus communicated with the anterior extremity of the ventricle. Although the writer does not consider the toxic agent, lead, as the immediate cause of the cerebral hæmorrhage, yet nevertheless it was the underlying cause of the apoplexy as it produced the cardio-vascular changes and the alterations in the renal parenchyma which brought about the cerebral hæmorrhage. The patient was thus predisposed to an apoplexy *i.e.*, in the most favorable condition for its appearance. The dangers of the cerebral arteritis was rendered the more dangerous on account of the increased pressure in the circulatory apparatus, due to renal changes. Plumbism like alcoholism predisposes to apoplexy. Like all the other vessels of the economy the cerebral vessels undergo changes. Many writers among which are Juengst, Roblot and Gosselin have studied these vascular lesions in poisoning by lead. But the vascular lesions are not the only factors in the production of cerebral hæmorrhage. From the observations of the writers above mentioned it has been discovered that the entire brain is affected with a chronic, diffuse meningo-encephalitis. Besides the cerebral arteritis and the apoplexy it is known that lead is one of the poisons which most profoundly affect the central nervous system. In both the acute and chronic form of the disease the brain is affected. This has been noted by both clinicians and experimenters. Without multiplying the list of those who have investigated this subject it may be stated that cases of acute fatal poisoning by lead have been described where the brain symptoms were most prominent. The cases of Stewart, Blyth and Triborn and the experiments of Combemale and Francois upon dogs are of interest from this point of view. In industrial centres where there are lead works, as Newcastle and where Oliver recently made 135 observations of acute lead poisoning the cerebral manifestations are not by any means rare. In the numerous observations of saturnine encephalopathy one often

sees the patient succumb to cerebral hæmorrhage. Amongst the five cases of meningo-encephalitis due to lead which Perelle reports in his excellent monograph one is recorded that of Dowse, in which a subarachnoid hæmorrhage occupied the parietal and occipital lobes with degeneration of the gray substance and sclerosis of many portions of the brain.

In 1877 Landonzy described a case of right-sided hemiplegia in a compositor (typesetter) who had previously suffered from lead colic and at the necropsy an o.d hæmorrhagic focus was found in the left centrum ovale which had caused a descending sclerosis of the spinal cord and a muscular atrophy with corresponding increase of the subcutaneous fat. Examination of these facts, continues the writer, shows that one may enlarge the field of anatomical lesions from lead poisoning and accept the rational conclusions of Westphal set forth in his recent monograph on this subject, "Saturine Encephalopathy," and admit that besides the direct action of lead upon the cerebral vessel-cells its injurious action on the cerebral vessels and the combination of these manifestations from the brain with the renal and frequent uræmic symptoms of saturnism. The history of the author's case offers nearly all the successive and concomitant effects of chronic lead poisoning, its digestive symptoms, colics, respiratory affections, etc. The action of the poison continuing the anæmia arrives at a terminal period, for one determines the presence of an anæmic murmur in the vessels of the neck without any appreciable sound at the orifices of the heart. The heart hypertrophies at the same time that the arteries sclerose; and, again, at the same time the interstitial nephritis, atrophic nephritis develops. Finally the cerebral symptoms set in, with stupor and persistent headache, the adhesions of the meninges to the surface of the convolutions and the lesions of the cerebral arteries are sufficient to explain the sudden rupture of the artery and the terminal apoplexy.—*Gazetta degli Ospitali*, No. 25, 1892.

INTERMITTENT QUARTAN FEVER.—Dr. Treille, of Algiers, in a communication, presented the following conclusions, drawn from a large number of cases:

Malaria manifests itself in all countries under three well-known types: quotidian, tertian and quartan fever. Intermittent quartan fever is the second attenuation of the quotidian, the primitive type of malarial fevers, the tertian being the first degree of weakening of the pyretogenous germ. These three types differ from the states known as pseudo-continuous fevers, pernicious ague, palustral cachexias and megalosplenias (enlarged spleen). The writer has had, in two years, thirteen cases of enlarged spleen under his care. In none of these cases could he establish any relation between the enlargement and the typical intermittent fevers. These splenic enlargements are apparently due to infections from the digestive tube. By abandoning intermittent fever, and especially the quartan type, to itself, the writer has not been able to observe any of the states recorded as malarial cachexia. Hence it appears that it cannot be the same thing. The writer calls intermittent fevers alluvial fevers, as they are found where there is alluvial soil and only a very short period on high plateaus, say from the 15th of August to the 15th of September, during which time the most favorable conditions of heat and humidity are to be found there. The term paludal fever, employed to designate them, is improper. The marsh types, as those of New Caledonia, never produce them. In Algeria the marsh fever is a great rarity. The river, with its rich alluvial, is the cause, as a rule. The quartan fevers yield very rapidly to small doses of the sulphate of quinine, given at the beginning of the attack. One case which the writer has treated for twenty-two successive attacks, the attack yielded to five centigrammes of the sulphate of quinine, and did not reappear for six days. When one sees the quartan fevers disappear after such easy treatment, one is surprised to hear that writers place them in the same category as the so-called pernicious attacks. Besides, these fevers, the quartans, if left to themselves, never transform themselves into pernicious fevers. The group of alluvial fevers is therefore without a similar in pathology. It differs from all other marsh affections.—*Le Bulletin Medical*, No. 50, 1892.

THE GASEOUS CONTENTS OF THE STOMACH.—M. Hope Seyler has analyzed the gas which in dyspepsia distends the stomach so painfully. He finds that it is chiefly hydrogen and carbonic acid, the former due to butyric fermentation. When the normal amount of hydrochloric acid is absent, the gas is almost entirely carbonic acid. In dilatation of the stomach a quantity of air is present also.—*Provincial Medical Journal*, September, 1892.

TREATMENT OF GOITRE, SYNOVIAL CYSTS AND HYDROCELE BY A SOLUTION COMPOSED OF IODOFORM AND ETHER.—Tincture of iodine is, as is well known, the classical treatment for the above affections, but it has the inconvenience of being very painful, especially in hydrocele. The solution of iodoform is, on the contrary, almost entirely painless. M. Dury employs a 10 per cent. solution, and injects two or three drops into the base of the goitre, then withdrawing the needle slightly, he inserts it into another point, and so on, until a few drops are placed in every direction. A rapid cure follows. In three cases of hydrocele thus treated the pain was little or nothing, and the result excellent.—*Medical Press and Circular*, July 27, 1892.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

TECHNIQUE OF THIERSCH'S METHOD OF SKIN-GRAFTING.—Abbé and Dunham (New York) report several successful cases operated by this method. In one, there being a few grafts left over, they were kept in salt solution twenty-four hours, and then "took" when used on two ulcers.

The success of the operation depends upon careful attention to every detail. The size of the area to be covered makes but little difference.

1. *Preparation of the Surface to be Grafted.*—Recent wounds, traumatic or operative, only require perfect disinfection and then douching with salt solution (a drachm and a half to the quart of boiled water). A granulating wound should be washed every second day with soap and water and bichloride (1 to 1000), and dressed with iodoform gauze saturated with balsam of Peru. This must be repeated until the surface is level, rosy and firm, which may require two weeks. Disinfection with bichloride and the salt douche are used, as in recent wounds, before the operation.

2. *Preparation of the Thigh for Removing Grafts.*—It is scrubbed with soap and bichloride, shaved and kept in contact with wet sublimate gauze for twenty-four hours. Shortly before the operation salt solution compresses are applied. These are protected with two bichloride towels, held by bandages at the knee and groin; they are turned up and down at the last moment, serving to surround the area to be operated.

3. *Instruments, Solutions, and Dressings.*—Two razors should be provided, as the edge loses its keenness, and they should be ground flat on one side. Salt solution at the temperature of the body is used for irrigation and disinfected hands, instruments and sponges. The dressings are bichloride gauze, bandages and protective, soaked in salt solution before using.

4. *Position of the Patient.*—The thigh should form a bridge six inches from the table, the hips, back, head and leg being raised by pillows. If an extremity is to be grafted, the limb is suspended vertically.

5. *Operation.*—While an assistant draws the skin tense by grasping the thigh on either side, the operator steadies the skin at the other end with his left thumb, lays the razor upon it at a slight angle, makes a sawing motion, and, at the same time, increases the angle until the razor bites into the skin. Continuing the sawing motion, a graft comprising from a third to a half of the thickness of the skin is shaved off. This is broadest in the flat region of Scarpa's triangle, but it may be carried nearly the whole length of the thigh. The resulting raw surface should be pearly white and ooze but slightly. The grafts are placed in lukewarm salt solution, and will curl up with the raw side in. To apply them to the raw surface, one end is held by the finger and the graft is rapidly uncurled, by a to-and-fro motion, with the aid of a probe. It can then be moved to any position desired. If the edges of the wound are abrupt, the grafts should run up and overlap the skin; so, too, they should touch or overlap each other until the whole raw surface is covered.

6. *Dressings.*—Strips of gutta-percha tissue are now unrolled over the grafts, overlapping each other and the edges of the wound, any blood being carefully washed off with salt solution. Bichloride gauze wrung out of salt solution is then applied (or a bandage if on an extremity); then a layer of gutta-percha tissue to retain moisture; then bichloride gauze, cotton, and immobilization splints and ban

dages. The raw surface left by the removal of the grafts is covered with gutta-percha tissue, gauze and a bandage.

7. *After Treatment.*—The grafted surface is dressed every second day with the same strict precautions. The gutta-percha strips are removed by curling them back sharply on themselves, and keeping this up as they are stripped off of the grafts. The surface is drenched with salt solution and dressed as before, the same strips of protective being used again, after sterilization in bichloride and rinsing in salt solution. After forty-eight hours the grafts will be rosy, abrupt margins will have become reduced, and the surface will be nearly flat. At the end of ten days healing will be complete but a cloth spread with vaseline had better be worn for a week or two longer. An area of seventy-two square inches has been covered in this manner in two hours, smaller areas requiring proportionately more time.—*The Post-Graduate*.

DIFFICULTIES AND DANGERS ARISING FROM INDISCRIMINATE ATTEMPTS AT THE REDUCTION OF STRANGULATED HERNIE BY MANIPULATION.—Bennett (London), in a clinical lecture, describes two illustrative cases and gives the following as dangers of over-zealous taxis.

1. *Bruising of the Bowel.*—Taxis is thought by most physicians to be at least harmless, if it fail to reduce the rupture. In most cases that have been manipulated there will be found evidences of bruising, shown by sub-peritoneal extravasations of greater or less extent. These are always associated with bleeding into the intestinal canal. Such hæmorrhages will vary with the amount and direction of the force applied and the condition of the gut; furthermore, unless persistent, careless, and excessive efforts at reduction are made, as a rule no permanent harm results.

2. *Laceration of the Bowel.*—This may involve all the coats, but usually the peritoneal and muscular, and is situated at the prominent, bulging, and most distended portion of the loop. Prolonged pressure at the ring causes perforation at the point constricted. Such rents are to be sutured, extreme distension being reduced by puncture with a trocar.

3. *Rupture of Adhesions in the Sac.*—Such a result is only serious when free bleeding is produced, or the peritoneal or other coats are torn from the intestine.

4. *Rupture of the Sac.*—This must of necessity be a rare complication, and is overshadowed by a rupture of the gut which is likely to accompany and precede it.

5. *Hæmatocele* occurred in one of the cases described, through rupture of a co-existing hydrocele.

6. *Hæmatoma from Rupture of Large Veins Outside the Sac* occurs at times and to an enormous extent, after even gentle manipulations in the aged.

7. *Reduction "en bloc,"* in which the tumor disappears without relief of the strangulation, may take place without violent or persistent taxis, and should always be thought of when the symptoms persist after reduction.

The relative safety of manipulative treatment depends upon three conditions:

1. *The Mode of Applying Taxis.*—This appears elementary, but is outrageously abused in practice, and is, of course, best learned by practical demonstration. The more important details are:

(a) All manipulations should be conducted with *warm* hands.

(b) The hernial neck should be firmly grasped by one hand while the other manipulates the tumor.

(c) Pressure should be made by the front of the digital pads, and never by the finger tips.

2. *The Time which should be Occupied by Taxis.*—Five minutes should be taken as the outside limit for the manipulation of a hernia. If at the end of this time success is not attained, it is very unlikely to result at all, and an extension of time is liable to be productive of harm.

3. *The Condition of the Hernia.*—Taxis may be used with safety in cases in which a true hernial impulse, even though very slight, is perceptible. In the absence of such impulse, and where manipulations have been already used, immediate operation is indicated. Large, distended hernie, with resonant note, should be handled with more than usual gentleness, while those that are dull on percussion and contain omentum or fluid, may be manipulated with more freedom.

In operating, the constricting ring should be freely divided. This is the first essential to prevent injury to the gut in reduction, and applies not only to the

fibrous constriction, but also to apparently loose folds about the neck of the sac, which are rendered tense and become obstructions when the gut is reduced.—*London Lancet*.

HERNIA, OPERABLE AND INOPERABLE.—Manley (New York), draws the following conclusions:

1. As no operative technique has been devised which will always effectually remove the causes of any species of hernia, permanent cure, in certain cases, is out of the question.
2. The radical operation for hernia is one of the most satisfactory in general surgery. Relapses occur in this as in most operations.
3. Operations for non-strangulated hernia, which gives no serious inconvenience, are not justifiable, without good reason, such as, neoplasm, ovary, or other viscus in the sac.
4. Extremes of age are contra-indications to radical operations. In early life there is seldom pressing necessity for them; in advanced life the risk, immediate and remote, as a rule, out-balances the prospective benefit.
5. Inguinal hernia, unless strongly contra-indicated, should always be operated in women, as a permanent cure so often results.
6. All operations on reducible or incarcerated herniæ may be considered radically curative, in spite of frequent relapses, for the immediate danger of strangulation is removed and a truss can be more easily worn.
7. Every operation for strangulated hernia should include an attempt at radical cure.
8. Very large, old herniæ, in any abdominal region, are inoperable, except when strangulated, because their sudden return is often attended with mortal consequences.—*Medical and Surgical Reporter*.

INCISIONS THROUGH THE VAGINA INTO THE ABDOMINAL CAVITY.—Segord advocates this route for entering the abdomen for growths or swellings that project downward, and as a diagnostic measure. Such an incision is attended with but little danger. Several cases are cited: 1. Supposed retroversion and fibroma, shown by vaginal incision to be a tubal foetation, which was removed. 2 and 3. Supposed fibroid found to be ovarian cysts; removed through vaginal opening. 4. Supposed pelvic abscess, shown to be a hæmatocele which was washed and drained.—*Lancet*.

HÆMORRHAGE AFTER TONSILLOTOMY.—Hovell (London), in several cases of hæmorrhage after excision of the tonsil, when cold, astringents and pressure had failed, has successfully made use of the following procedure:

One part of gallic acid was mixed with three parts of tannic acid, and enough water added to make a very stiff paste. This was rolled into a ball about the size of a marble, introduced into the mouth on the forefinger, and rubbed firmly into the bleeding surface, counter pressure being made at the same time with the other hand on the outside.—*British Medical Journal*.

THE MECHANISM OF HEAD INJURIES.—Miles (Edinburgh), in an essay on this subject, concludes that:

1. The group of phenomena commonly spoken of as "concussion of the brain" is the result of a temporary anæmia of that organ.
2. This anæmia is the reflex result of stimulation of the restiform bodies and perhaps other important centres in the region of the bulb.
3. That these parts are stimulated by the wave of cerebro-spinal fluid, which rushes through the aqueduct of Sylvius, foramen of Magendie, and from the sub-arachnoid space of the brain to that of the cord when a severe blow is dealt over the skull.
4. In accordance with the laws of hydrostatics, this cerebro-spinal fluid wave will disturb the equilibrium of the ultimate nerve cells throughout the central nervous system.
5. The hæmorrhages found throughout the brain substance and on its surface are to be ascribed to the recession of the cerebro-spinal fluid, which naturally supports the vessels of the cerebrum.
6. The petechial hæmorrhages found in cases of so-called concussion are not the proximate causes of the symptoms of that condition. They are rather to be looked upon as an index of the force producing the injury, than as the cause of the resulting phenomena.—*Brain*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

TEUCRIUM SCORDIUM IN PRURITUS OF THE VULVA.—Thirty years ago Dr. Lebel prescribed this remedy for the unsupportable itching which sometimes accompanies hæmorrhoids.

Dr. John Brinton has recently made a study of it and believes it to be very efficacious for the pruritus caused by hæmorrhoids. It stimulates appetite, calms nervous irritation, and soon relieves the itching in the anal region.

Contrary to expectation, teucrium succeeds very well in pruritus of the vulva, when it is not caused by diabetes.

Chéron gives the following treatment for pruritus of the vulva :

1. Warm vaginal injections, morning and evening, with two tablespoonfuls of boracic acid to the litre of water.

2. Lotions three or four times daily on the vulvo-anal region of equal parts of warm water and Van Swinten's liquor.

3. A half hour after each meal take, in a little water, one of the following powders : Powdered leaves of teucrium scordium—5 grammes in 10 powders.

By this mixed treatment pruritus of the vulva disappears in a few days, when it is not the result of diabetes. The cure is not lasting without appropriate treatment for the vaginitis, endometritis polypus, or whatever may be the cause of the irritable discharge which is the veritable cause of the pruritus.—*Journal de Medicine de Paris*, 1892, p. 354.

A RÉSUMÉ OF DÆDERLIEN'S WORK ON VAGINAL SECRETION.—As the streptococcus is the only pus organism which has as yet been shown to play any part in the production of puerperal fever, even the pathological secretion is only dangerous in about 10 per cent. of the cases. Dæderlien believes the streptococci can reach the interior of the uterus only by being carried there by manipulations of some sort or another. The examination of the vaginal secretion is made a part of the routine practice at the lying-in hospitals at Leipzig. Students are not allowed to examine cases if the secretion is pathological. The employment of injections of a 1 per cent. solution of lactic acid gave the most satisfactory results in the effort to restore the secretion to its normal consistency. It apparently offered an unfavorable medium for the growth of pathogenic organisms.—Dr. J. W. Williams, *The American Gynæcological Journal*, May, 1892.

MORPHIA IN THE TREATMENT OF ECLAMPSIA.—In the discussion following the reading of a paper on this subject, morphia was most strongly recommended as the drug for controlling the convulsions. Chloral, in one-drachm doses, was the next in favor.—*The American Gynæcological Journal*, May, 1892.

THE CONSERVATIVE TREATMENT OF SALPINGITIS.—Mundé emphasizes the fact that a mere slight, more or less acute, or subacute inflammatory enlargement of the Fallopian tube, even though it can be entirely detected by the finger per vaginam, does not warrant the removal of the diseased organ until all palliative means have been tried, and tried again without avail. The mere presence of catarrhal salpingitis, with or without adhesion, with or without agglutination of the tube, with or without closure of its fimbriated extremity ; the mere presence of a certain amount of pain in these regions, does not by its self warrant us in removing the diseased organs.—*The American Journal of Obstetrics*, July, 1892.

HAGEE'S SIGN OF PREGNANCY.—An apparent separation manifests itself, not in the cervix but above the internal os in the lowest portion of the body. It is wrong to look for the characteristic compressibility as low as the supravaginal cervix. Here it could show itself only when a portion of the supravaginal cervix has really been drawn up to form a part of the uterine cavity. Even though there be a diminished consistence of the supravaginal portion, it is distinctly less marked than the pronounced difference between corpus and supravaginal cervix. Some latitude must be left to individual estimation, and if we wish to draw a definite limit for the absolute demonstrative power of the sign, it will be best to set the upper limit of a compressibility to an intermediate layer of thickness of one-half

centimetre below this limit to an apparent complete separation of the body and cervix. Firm reliance can be placed on this sign in diagnosis, according to the author's experience.—Ernst Sonntag, M.D., *The American Journal of Obstetrics*, August, 1892.

THE OPERATIVE TREATMENT OF RUDIMENTARY DEVELOPMENT OF MÜLLER'S DUCTS—GLAESER.—Laparotomy is indicated for vaginal defects where there is a doubtful diagnosis of hæmatometra, hæmatosalpinx, or ovarian tumor with ovarian symptoms.

If there is a positive diagnosis of hæmatosalpinx, laparotomy is necessary without previous incision of the vagina if not developed.

A collection of blood in the vagina requires careful provision for a slow discharge of it.

The discovery of an enlarged tube or sac after emptying the vagina and uterus is always an indication for immediate laparotomy.—*Centralblatt für Gynäkologie*, No. 33, 1892.

ASCENDING GONORRHOEA IN WOMEN—WERTHEIM.—The characteristic symptoms of ascending gonorrhœa are: profuse menorrhagias, atypical often severe hæmorrhages and painful menstruation. Zweifel is of the opinion that the symptoms are important in making a differential diagnosis of tubal infection from streptococci or gonococci. Patients having pyosalpinx from the former cause do not complain of irregular, excessive or painful menstruation. Wertheim concludes that ascending gonorrhœa through the gonococcus is a direct cause of inflammatory processes in the tubes and ovaries, in the peritonæum and tissue of the broad ligament. There is no reason for ascribing the disease to a secondary infection.—*Archiv. für Gynäkologie*, xlii., Bd., H. 1, 1892.

THE IODOFORM GAUZE TAMPON IN THE UTERINE CAVITY FOR POST-PARTUM HÆMORRHAGE—DÖDERLEIN.—This use of the tampon does not restrain hæmorrhage so much by mechanical pressure, as by continuous irritation of the uterine cavity it excites a strong and permanent contraction of the uterus, and, if properly introduced, is a safeguard against atonic hæmorrhage. It is not wise to pack the uterus as tightly as possible, and, on account of its antiseptic properties it is not to be considered a final resource, like cotton tampons or perchloride of iron. It should be introduced in a continuous strip by the hand alone to the fundus uteri till the cavity is full. The uterus contracts speedily and a large amount of gauze is unnecessary. This tampon is removed in twenty-four hours. Zweifel prefers this use of the tampon to perchloride of iron.—*Centralblatt für Gynäkologie*, No. 33, 1892.

OVARIOTOMY DURING PREGNANCY.—DSIRNE.—The complication of pregnancy with an ovarian tumor is, in many cases, a serious complication, which requires relief in most instances by the removal of the tumor.

The further pregnancy has progressed, the more dangerous is the operation for both mother and child. The puncture of the cyst or the interruption of pregnancy should be employed only in emergencies. Ovariectomy gives the best results for the mother in the second, third and fourth months of pregnancy, and for the fœtus, in the third and fourth month. If for any reason an early ovariectomy was not possible, it should be performed even near the close of pregnancy, as good results may be obtained at that time.—*Archiv. für Gynäkologie*, Bd. xlii. H. 3, 1892.

THE VAGINAL EXTIRPATION OF THE CANCEROUS UTERUS—WOLTER.—This operation was performed forty-seven times in the General Hospital, in Hamburg, from 1880–1890. He considers the danger of recurrence is much greater in women who are still menstruating. Wolter agrees with other authors that chronic endometritis precedes and plays a part in the ætiology of cancer of the cervix uteri. One case was observed which apparently confirmed Fritsch's opinion that curetting prior to hysterectomy opens the lymphatics which absorb the débris and thus recurrence is favored. Schede has recently decided that the radical operation should immediately follow the use of the curette. It is important not to allow any carcinomatous material to touch the peritonæum during an operation. When the neoplasm is very extensive and can be but partially removed, the course of the disease is shortened, the rapidity of growth increased and the duration of life diminished thereby.—*Centralblatt für Gynäkologie*, No. 31, 1892.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

DERMATOL IN EYE DISEASE.—R. Roselli (*Rif. Med.*, July 7, 1892), encouraged by the favorable results of numerous experiments upon rabbits, has tried dermatol in the human subject in 25 cases of pustular conjunctivitis, 14 of simple or phlyctenular keratitis, 11 of parenchymatous keratitis, 9 of ulcer of the cornea, 5 of trachoma and pannus, 4 of blepharitis, 3 of kerato-hypopyon with complete infiltration of the cornea, and 2 of diphtherial conjunctivitis. The insufflation of dermatol in cases of pustular conjunctivitis of scrofulous origin, with or without the simultaneous administration of the iodides, gave excellent results. Good results were also obtained in cases of corneal opacity and simple and parenchymatous keratitis, iodides being given internally and atropine being instilled when indicated. Dermatol was found useful in corneal ulcers, especially those of traumatic origin, and also in the cases of kerato-hypopyon after emptying the anterior chamber. In blepharitis it was of little or no use. It proved very serviceable in the cases of pannus, but no effect was observed in the trachoma cases. In the cases of diphtherial conjunctivitis the insufflation of dermatol modified the secretion and prevented the formation of false membranes.

ELECTROLYSIS IN THE UPPER AIR-PASSAGES.—Dr. L. Grünwald has treated seventy-four cases by this means. He has never used more than twelve cells of a simple battery, and the current strength is never over fifteen milliamperes by the galvanometer. In chronic pharyngitis a double platinum needle was inserted into the swollen, irritable spots, and a current of from ten to fifteen milliamperes used for from ten to sixty seconds, generally without previous cocaineizing.

The reaction is generally very slight, and there is usually no pain. In extensive affections the needle is applied to several places at one sitting. One sitting is usually enough to remove the annoying symptoms. The writer considers this method far superior to acids or the galvano-cautery.

In chronic nasal obstruction the current strength is from five to fifteen milliamperes, used for one-half to five minutes. The pain is considerable, but cocaine does not affect it, and is not used. The pain is generally well-borne. From one to five applications generally suffice. The action is principally to destroy sensitive nerve-ends, diminishing abnormal irritability. Electrolysis in tuberculosis of the larynx was not very successful.—*International Medical Magazine*, August, 1892.

TEMPORARY DYSPHONIA PRODUCED BY A TUMOR OF THE NECK.—(*Archivos Internac. de Rhinologia, Laringologia y Otologia*, No. 14, 1892).—Dr. Pergens speaks about a young man of sixteen years of age, employed on a farm, and having a tumor on the superior part of the right side of the neck. Each time he exposed himself to a current of air he lost his voice and then felt a constriction in his throat. There was only a distension of the skin on the right side of the neck, extending from the angle of the inferior maxilla to about two centimetres of the mental process. The laryngoscopic examination showed nothing abnormal. During an attack of aphonia naught could be distinguished on the outside of the neck, but in the larynx the left vocal cord only could be seen, the right one being concealed by a round swelling covered by normal mucous membrane. After a short time of rest, the patient regained his voice. Dr. Pergens removed the hypertrophied submaxillary gland and adjacent ganglia, after which operation the aphonia did not return. Probably the temporary dysphonia was produced by chilling of the diseased glands.

DEFLECTION OF THE NASAL SEPTUM.—Mr. Mayo Collier contends (*Journ. of Lar. and Rhin.*, No. 12), that an enormous number of deflections of the septum narium are due to paralysis or paresis of the muscles of the nose. He has carefully examined the septa of more than one thousand living subjects, and he finds that some deflection or irregularity is within 10 per cent. a constant feature of adult life, while it is only in young persons under puberty in whom we may expect to find a majority of normal septa. He calls attention to the fact that 80 per cent. of savages and aborigines have undeflected septa. Then he argues that obstructions in the nasal passages, whether the result of catarrhal or other causes, increase the external air pressure by rarefaction during inspiration, and that these successive pressures or blows long continued, must bend the thin and yielding portions of the septum inward.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,

FRANK H. PRITCHARD, M.D., AND E. M. HOWARD, M.D.

PERIOSTITIS, CARIES AND NECROSIS OF THE ORBITAL WALLS.—In closing a lecture on this subject, Dr. Hayes C. French presents the following remedies with their indications:

Arsenicum iod.—In scrofulous diseases of the orbital walls with eroded borders and corrosive discharge.

Aurum mur.—A useful remedy in orbital caries, periostitis or necrosis, especially if complicated with mercurial or syphilitic poisoning, or scrofulous taint. The pains are severe, referred to the bones, and worse at night (or morning and evening), the parts are sensitive to touch and the patient to pain.

Asafetida will often relieve the severe boring pains around the orbit and change the fetid and excoriating discharge to laudable pus. The pains are relieved by pressure.

Calcarea fluorica is indicated in exostoses with roughened elevations on the surface of the bone; in hard bone swellings and nodes, and also in caries from syphilis or abuse of mercury.

Calcarea phosphorica.—As a fine factor in neoplastic cell life will be found an important remedy in orbital caries or necrosis, especially in chlorotic or scrofulous subjects.

Calcarea sulphurica will be found a most important remedy in all forms of disease of the orbital walls, especially in the chronic. It acts deeply and profoundly upon these structures.

Kali iodatum has long enjoyed great favor in diseases of the orbital bones, especially in syphilitic and mercurialized subjects. The pains are variable in degree, and worse at night. The use of the crude drug in small doses, two to five grains, and the lower triturations seem to be the choice of the major part of the profession.

Kali sulphuricum.—In chronic diseases of the orbital bones with watery and exco-riating discharge, when the characteristic symptoms of the drug are present, amelioration in the open air, and aggravation in a hot room, it will be found an important remedy.

Silicea is one of our most useful agents in chronic diseases affecting the integrity of the orbital walls, and seems to exert a specific influence over necrosed bone, promoting the exfoliation of sequestra, and favoring the offensive discharge. Its action is deep and long-lasting, and while it resembles mercury in its general effect, it does not follow well the use of that drug. The pains of *silicea* are worse at night, during full moon, and better from heat or warmth.—*California Homœopath*, August, 1892.

CLINICAL ITEMS. *Jatropha.*—Diarrhoea, with loud gurgling in the abdomen.

Sepia.—Passive uterine congestion, indicated by sacral pains, dragging sensation of womb, bearing down feeling and prolapsus; much itching all over.

Taraxacum.—Was recommended by Hahnemann as a remedy for diabetes. It corresponds to many of the accompanying liver and pancreatic symptoms of this disease.

Iodine.—Great weakness about the chest. Voracious appetite, yet loses flesh; palpitation, morning cough with hoarseness.

Lupulus.—Unstrung condition of nervous system attended with nausea, dizziness, headache, after abuses of liquor.

Selenium.—Pain worse after sleep. Itching of nose; sexual neurasthenia, debility and relaxation of organs.—*California Homœopath*, August, 1892.

POISONING BY CICUTA VIROSA.—Dr. T. G. Stonham reports the case of a girl aged eight years who was said to have fallen down in a fit in the street. When he first saw her she was on the ground, vomiting, and crying out as if in terror. She was quite unconscious of her surroundings. There was considerable tonic spasm, especially of the extensors of the limbs and of the muscles of the back and neck; the abductors of the thighs were also spasmodically affected; the tonic was nearly continuous, but greater at times; there was never relaxation of all the muscles, but at times of most of them. The pupils were somewhat dilated, the face very pale, almost livid; the surface of the body cold; the pulse scarcely perceptible at the wrist; breathing quiet and rather shallow. There was vomiting of glairy mucus, with some pieces of white substances of acrid odor. The teeth were tightly clenched, and it was with much difficulty that she could be got to swallow a teaspoonful or two of mustard and water. The stomach pump was sent for. In the meantime she was seized with a well-marked epileptic convulsion. It commenced with extreme dilatation of the pupils, then the lips began to twitch on the right side, and the eyes to be directed to that side; immediately all the muscles on that side of the face were twitching violently, the head was twisted to that side by the muscles of the neck, and the right arm and hand were clonically convulsed, the convulsion soon involving the left extremities as well. Soon the convulsive movements left the right side of the face and passed over to the left side, and then when the whole left side had become as much implicated as the right, and the patient extremely cyanotic, a long-sighing respiration ended the attack. As many as twelve of these attacks, each lasting about three minutes, occurred within the next hour and a half. Between the attacks there was a good deal of opisthotonos and tendency for the arms to be drawn back. Immediately after the attack there was relaxation of almost all the muscles except those of the jaw, which were kept firmly contracted. The tongue was bitten during the convulsions, but there was no passage of urine or feces. In all the convulsions the attacks passed completely from one side of the body to the other before the attack culminated. They did not always commence on the same side.—*Monthly Homoeopathic Review*, September, 1892.

CACTUS.—In a study of cactus, Dr. Burt F. Storke says that the remedy is called for where digitalis, strophanthus and convallaria seem indicated, yet fail to relieve the distressing symptoms. And yet cactus is the direct opposite of digitalis in many ways. Digitalis is called for in asthenic or over-stimulated condition of the heart. Cactus is an asthenic. Cactus has the constriction as of an iron band; digitalis the feeling that the heart would stop beating, if she moved. The palpitation of cactus is increased by walking and at night when lying on the left side; so is that of digitalis, but there is the feeble, fluttering pulse, which a cactus never has. Cactus always has the iron band, suffocation, the cold sweat; digitalis the irregular, fluttering pulse, the feeling as if the heart stood still, with anxiety and oppression. Strophanthus always has the pressure and uneasiness in the region of the heart. As in gelsemium, the malarial feature in cactus is marked and valuable, but here the similarity ends.

The key-notes of the drug are:

Patient is hypochondriacal, fears death, believes disease incurable; is sad, weeps much, and wants to be alone.

If there is a headache, it is most liable to be a pain like a weight on the vertex, relieved by pressure, made worse by the sound of talking and by any noise.

Vision is weakened or lost, with circles of red light.

Profuse nose-bleed.

Face pale and emaciated.

Anorexia.

Everything tastes acid.

Copious vomiting of blood.

Gastro-enteritis.

Constriction of scrobiculus cordis.

Heaviness and pulsation in the pit of the stomach.

Profuse hæmorrhages from the bowels.

Sensation of great weight and urging to evacuate a large quantity, but nothing passes.

Frequent desire to urinate at night, with a copious flow each time.

Urine reddish and turbid, or straw-colored.

Painful menstruation, causing loud cries.

Menses eight days too soon.

Flow stops when lying down; begins again on rising.

Catarrhal cough, with much viscid expectoration.

Hæmoptysis.

Dyspnoea, with oppression and uneasiness, as if the chest were constricted by an iron band.

Periodical suffocation, with faintness; cold sweat on the face and loss of pulse.

Constriction of the chest, as if bound.

Worse on motion, with oppression of breathing.

Congestion which prevents his lying down.

Pricking pain in the heart.

Acute pain with stitches, which cause loud cries.

Heavy pain, worse on pressure.

Sensation of iron band.

Increased action of the heart all the forenoon

Fever every day at the same hour.

Coldness in back and icy cold hands.—*Medical Current*, August, 1892.

POISONING FROM STANNUM VAPOR.—A correspondent of the *Homœopathic World*, September, 1892, thus tabulates the effects produced by the vapors of tin in those working in that metal:

Neuralgias, most intense, persistent and periodic, capricious as to locality.

Headache. Physical depression profound and often with suicidal impulses.

Anorexia accompanies the above conditions. Others seem to have a special tendency to thoracic (pulmonary) affections, hæmoptysis, hæmatemesis, cough a la phthisic pulmonaire. Sternum from throat to umbilicus feels raw and sore. Pain through chest from sternum to below scapulas, which causes an habitual stoop.

Expectoration profuse and of various description, often as much as a pint during the night.

Night-sweats. Hectic flush in the evening. Fever. Insomnia.

Dyspnoea. Pulse rapid, small, feeble.

Emaciation. Terrified aspect, etc.

In some cases, the nervous system seems chiefly affected; in others the digestive, vegetative process; in others the pulmonary thoracic tract.

Bryonia seems to benefit each and every case, the profound depression, etc., vanishing as if by magic, and enabling the sufferer not only to resume his work, but to continue the same.

Phosphorus amorphous, 10x trituration diluted in water, gives most satisfactory evidence of its curative action in the pulmonary thoracic subjects.

Arsenicum seems preferable in the neuralgic subjects.

DR. MACFARLAN'S PROVINGS AND CLINICAL OBSERVATIONS WITH HIGH POTENCIES.—*Cina* 12c.—Violent coughing, lasting a great part of the night, as if she should strangle; lacking confirmation, but believed to be reliable because a similar cough has been often relieved by this remedy.

Camphor 60m.—Hæmorrhage from the nose, occurring once a day or oftener; difficult to check, weakens him very much, never troubled so before; verified this often in many provers of camphor. It is one of the most effective remedies in persistent nose-bleeding.

Cupri-acetas. 45m.—Cured an old case of scrofulous ophthalmia in a child when other remedies failed. This I have often verified.

Cochlearia-arm. 10m.—Profuse painless diarrhœa, not sick with it, hungry feeling, unnatural craving for food.

Copaiba cm.—Given in water every two hours produced after several days symptoms of strangury in a male; caused burning sensation in pharynx and tickling cough without expectoration.

Digitalis-purpurea cm.—Produced throbbing in every part of the body when touched; free diarrhœa; choking when he tries to swallow; thirst; great weakness in chest; constant disposition to void urine; does not wish to use his voice, because of feeling of exhaustion in chest.

Digitalis cm.—He coughs constantly at night, three hours at a time, as he states. Many provers say they cough a great deal day and night; raise phlegm; never did cough so before.

Dracontium fatidum 10m.—Cured severe aching pain in her *left* shoulder, constant belching and rumbling of wind in abdomen. The peculiar noise in the abdomen was like the gurgling of water, and could be heard over the room.

Dolichos-pruriens 2c.—Head feels as if it would separate, it pains so, aching through the apices of both lungs, bruised pain in left inguinal region, soreness below the umbilicus. The prover, a child with spinal curvature, had been subject to severe intestinal colic, occurring every few weeks, and which began five years ago; cure of colic was permanent and complete. The other symptoms developed were not recorded, because not confirmed by further provings.

Doryphora-decemlineata 45m.—Soreness in and oppression of the chest; inflamed throat.

Eupatorium-perfoliatum cm.—Oppression at the middle of the sternum; feels as if something was pressing against his heart; palpitation; pains her to get and take a full breath; chest oppressed; symptoms of bronchitis; sharp pain in the eyes as if needles were being inserted; attacks of chills in the morning, no fever, unable to get warm, so chilly; eyes not inflamed; throat dry; becomes at times hoarse and loses her voice; oppression in chest very great; sharp burning pain in the feet; could not keep her shoes on sometimes while pain in feet lasted; feet seemed swollen; frequent short, dry cough; sharp pain in left ankle, hip, and shoulder, come on instantly and go away as quickly; weak and sick. *Hoarseness*.—Prover, aged 45, general muscular soreness, worse in left ankle, left hip, left shoulder; *hoarseness* very great, can hardly talk; loses his voice; the trouble has passed down into his chest; hoarseness is greatest in the morning when he gets up; sudden violent contraction of the muscles of the right cheek; symptoms confirmed as to hoarseness and chest distress.

Erigeron-can. 45m.—Checked uterine hæmorrhages of long duration when other remedies did no good. This I have verified many times. Turpentine high has about the same effect.

Erethites-hieracifolia 10m.—Stitches in the middle of the back; cold feeling in the back and legs; pain and soreness across the lumbar region; sore throat; legs feel stiff and painful, and aching across the small of her back.

Eupion 45m.—Region of stomach felt internally sore and distended; not external soreness; pains under both short ribs.

Euonymus-atrop. 10m.—Urine increased; passes a great quantity at a time.

Ether-sulphuric 6c.—Remarkable effect in quickly curing severe neuralgia of the head in a woman aged 60; been confined to bed weeks with it; had raised welts or swellings on scalp like ridges, accompanying the pain.

Eupatorium-perf. cm.—Sharp pain through the right chest when he breathes deeply; feels at night as if he was going out of his mind; disturbed breathing frightens him; effect of the medicine after a week.

Ferrum-met. 80m.—Believed to control hæmorrhages in one disposed to consumption; had slight bleedings every week or two, but ceased entirely on exhibition of the remedy. Nausea; vomited daily for three days after taking the medicine; never did so before; stopped the proving; rash like measles in a woman aged 37; hands felt as if she couldn't shut them because of a swollen sensation; controlled or stopped slight hæmorrhages from the lungs and daily spitting of blood in young girl.

Ferri-carb. 50m.—Child aged seven years, four days' proving. Face suddenly red and purple, then pale; rest of body cold; extremities affected in a similar manner, alternating with slight fever and chilliness; changes are very rapid; stopped the medicine; have verified this in other provers.

Filix-mas. 1m.—Lost his appetite; if he eats anything he is inclined to reject it soon after being swallowed; giddiness.

Formica-rufa 45m.—Pains down the anterior surface of both arms: worse about the elbow, as if bruised; felt as if she was going to smother; throat very sore; eyes and head very much affected; difficult to think or use her eyes well; chest internally felt badly from the nipples upwards; as if she would raise a quantity of mucus; sensation as if she would have quinsy; left side of throat worse than right; cough very troublesome; cough strains her; it is so severe and constant. Lower extremities felt as if she had no power in them; sore and tired sensation across the abdomen below the navel, as if bruised; tired feeling in the back; felt slightly giddy.

Fluoric-acid 45m.—Pain in eyeballs; hacking cough; sharp pain through temples.

Ginseng 40m.—Soreness across his abdomen; severe pain on either side of the top of the head, which caused him to shut his eyes; ringing in his ears; hiccupping all day, off and on. Sneezing; blowing his nose: became hoarse coughing; sensation of cold in chest, sharp pain in lungs, bowels loose, griping pain in abdomen.

Guaiacum 5c.—Violent fever; her face became spotted, red blotches; eyes, nose, and cheeks have swollen appearance; tight, dry cough; muscles and joints of extremities sensitive.

Glanderine 12c.—Feet feel sore and tired: pains her every step she takes, particularly on the soles of her feet; right arm very sensitive; anterior surface of the elbow sore to touch; no nose or throat symptoms developed that were prominent.

Gummi-gutti—Left ear ringing constantly; sometimes hissing sensation, as of blowing off steam; right ear slightly affected.

Gelsemium semp. cm.—Her thighs were sore and sensitive to the touch; left more sensitive than the right; pains were all relieved when in a perspiration. This remedy cured the prover in three weeks. She had wry neck and was almost paralyzed; worse on left side; head drawn to the left side; inability to move the thighs but little; unable to get her hands to her head; had been in this way for several months; the subject of regular treatment for nearly a year previous to taking Gelsemium. Symptoms of another prover—eyes water, and inflamed; coughs a good deal during the night; left ear discharged a little; had not previously done so; caused very loose bowels; prover a weak, nervous woman, with glaucoma.

Gettysburg Spring Water 45m.—Bowels that were regular now costive. Another, bowels now loose, three to four times a day, that were costive; hoarse, dry cough, as if from a scraped condition of throat. This is the language of the prover. Pains in both shoulders and left knee; seminal emissions; urine profuse; sleepy and drowsy during the day; a good deal of pain in upper left chest in front; pains her when she takes a deep breath. Verified over and over again its good effect in muddy urine, excess of urates, in frequent urination, in hip-joint disease, and rheumatic gout.

Graphites cm.—Curative in provers with tinea tarsi. Improved dimness of sight, caused by unhealthy secretion about eyelids.

Hamamelis-virg. 10m.—Knocking, hammering sensation over left eye; throbbing sensation within the head; flushed face; inability to think well.

Hypericum-perfol. 45m.—Child nauseated; complains of great pain in stomach; sick whenever it eats; bowels loose, two to three times daily. Cured a prover having articular rheumatism (knees mostly) with great effusion around the joint, and muddy urine, which, in a few hours, looked like the settlements of beer. Caused severe pain in the last phalanges of the fingers, mostly thumb, fore, and little finger. Constant eructations night as well as day. Verified frequently its curative action in articular rheumatism and pains affecting small joints. Sores inside the nose, itchy, continually picking it. This symptom was noticed in many provers. Cured eructations, caused severe cholera morbus on the third day, which continued several days. Stye on lower left eyelid, muscles sore, bruised feeling. When she took her shoes off found her feet much swollen, urine greatly diminished in amount; remained so for three days after stopping medicine. *Fearful sharp pain in knees, could hardly touch them* (symptoms after two weeks, medicine eight times a day). This was the most prominent symptom. Next in importance was his head trouble—dull pain; pains shoot through his fingers as if they were becoming sore. Another prover, rheumatic woman, never passed so much water in her life; had to get up five or six times in night; great quantities at a time. Gave her relief from rheumatism.

Hellebore cm.—Pain within the chest under the left nipple; general muscular soreness; forced her menses on before the time; had to get up at night to pass urine. Another prover, cured painful straining; constant desire to pass water, with burning; don't need to get up at night to pass it as formerly; cured that symptom. Scanty urine in one prover where the secretion has been free.

Hepar-sulph. cm.—Did no good given alone in a case of real croup; with some sore throat spongia^{cc} afterward quickly cured the case. Verified this action of spongia often; partial loss of voice existed in these cases.

Hydrophobinum 1m.—Fever; no chill; pulse continuously rapid; no appetite; thirst; very sleepy; constant desire for cold drinks, which are swallowed without difficulty.

THE HAHNEMANNIAN MONTHLY.

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CASES OF CRANIAL FRACTURE WITH REMARKS AND PRESENTATION OF CASES.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
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IN looking over my notes for surgical work during 1891 and 1892 I find, among thirty-six operations on the cranium for lesions of its contents, fourteen for recent traumatisms and at least nine for the remote effects of injuries. In view of the great mortality in cases treated under the expectant plan, and of the resulting conditions in those that survive, such as epilepsy, imbecility and insanity, which are often worse than death, prompt recognition and as prompt radical treatment, when indicated, cannot be too strongly insisted upon. The operative surgery of the brain has swung from one extreme to the other in the past, and, thanks to the immunity given by antiseptic technique, we are now near the operative extreme. The many unsuccessful operations for the remote effects of injuries have done much of late to bring brain surgery into disrepute, and justly so, but the blame should not be laid at the door of the operation, for it really belongs to the treatment of the primary injury. Besides the "epileptic habit," for instance, there are definite sclerotic changes, which spread from the seat of the injury and involve large areas of brain tissue that cannot be affected by cutting out cicatrices, empty-

ing cysts, etc. (Sachs). From lessons learned in the treatment of these cases I feel that while we may be more skeptical or conservative in the surgical treatment of the remote effects of injuries we should be more prompt and more heroic in relieving pressure and removing irritants, in short, in preventing inflammation in recent traumatisms.

To my mind there can be no better place to discuss this important question than in a Society like this, where the general practitioner, the neurologist, the ophthalmologist, the otologist, and the general surgeon meet together.

I have selected the following cases because they are recent, and it is to the treatment and recognition of these that I am anxious to direct particular attention, as every hour of delay increases the danger to life and of subsequent brain impairment. They are also selected not so much for the results obtained, but as illustrating the different types of injury that we most frequently meet with.

I. *Open, comminuted, depressed fracture of the parietal and temporal (squamous portion), with laceration of the dura.*

W. B., 50 years old, laborer, operated June 30, 1891, was struck on the head by a block and tackle weighing about 150 pounds, which had fallen some fifteen feet. This had caused a large, ragged scalp wound, through which extensive comminution and depression of the squamous plate and the parietal could be made out, in the posterior and superior portions of the right temporal fossa. The wound was thoroughly cleansed, the scalp shaved and an antiseptic dressing applied by the house surgeon of the Hahnemann Hospital. There were no symptoms. When I saw him I at once enlarged the wound, trephined, elevated the depressed bone, removed several pieces which had perforated the dura, disinfected and closed the wounds in the latter, drained with iodoform gauze and sutured the scalp with silk worm gut.

There was nothing to note during the week he was in the hospital, and he is presented to the society for examination. It is now nearly fifteen months since the injury, and he enjoys good health and is in full possession of his mental faculties.

The indications in this case were clear and an operation imperatively called for, even in the absence of symptoms. Death would have probably resulted, but, if by disinfection and occlusion fatal brain inflammation had been prevented, the pressure and irritation must undoubtedly have produced changes that would have shown their effects afterwards.

In marked contrast with this case and showing the results of no treatment is the following:

II. *Open, depressed, fracture of the temporal bone (squamous portion) with laceration of the dura; encephalitis.*

Male, of middle age, after exposure to the sun, was, it is said, attacked with vertigo and fell against a hitching post, sustaining a contused wound two inches above and a little posterior to the bi-auricular line on the left side. He lost consciousness and remained in a stunned condition for thirty-six hours, when a physician was called in and the diagnosis of concussion made. Twenty-four hours later convulsions set in, which were thought to be apoplectic, fracture being excluded on account of the apparently slight injury. On the fourth day Dr. Bartlett saw him and insisted on an immediate, forlorn-hope trephining. The temperature, which was above 106° , was reduced to 103° before the operation by the use of the ice pack. There was the deepest possible coma, dilatation of the pupils, insensitive corneæ, complete paralysis of the extremities and sphincters.

The external wound was enlarged, and an inch below and anterior to it was found a depressed fracture of the squamous plate. The depressed portion was one inch long by one-half inch wide and perforated the dura. The trephine opening was very freely extended downwards and backwards, the lateral sinus being separated from the cranium and exposed, and the dura opened to a corresponding extent. A fulminating, septic meningitis was present with sero-purulent effusion, sticky membranes and enormous dilatation of the vessels of the pia.

The relief of the pressure was shown by returning sensitiveness of the cornea and some movements of the right side, but the patient died, and that, too, in a very few hours.

Had this man been seen at once, and the wound cleaned and dressed properly, his life might been saved; had he then been trephined and the depressed bone removed, there is but little doubt that he would have made a perfect recovery.

I desire right here to take exception to the term "concussion." There is the general impression, and I confess that I shared it, for which text-books and surgical teachers are to blame, or perhaps better, for which the tenacity with which we cling to antique nomenclature is responsible, that *concussion* is functional, *compression* is organic; or, in other words, the former means recovery, the latter death. Concussion, however, is produced by laceration, and, if recovery takes place with or without the intensified clinical picture known as compression, there are apt to follow reminders of the injury to the great nerve centres. They are both parts of cerebral traumatism and as such deserve the most suspicious observation.

The case was indeed a deceptive one at the beginning, and therefore instructive. A small, contused wound, which neither the

patient nor his friends noticed; a small depressed splinter, an inch from the wound, which could not have been made out from the wound, or through the scalp; and a history of probable sunstroke!

I recall two recent cases treated by careful and competent observers, which illustrate the difficulties in arriving at a diagnosis, and the importance of suspecting and investigating for fracture in every doubtful case.

1. A man was picked up on the street, drunk, and quickly developed what was considered delirium tremens. The head was carefully examined and nothing but a slight bruise found over the left eyebrow. The autopsy showed a fissure of the orbital and the vertical plates of the frontal, and a diffuse meningitis.

2. A man was picked up on the street and apoplexy diagnosed; when the scalp was shaved we found a contusion and a small wound above and behind the ear. He was vomiting profusely and died while we were preparing to operate. Fracture was the cause of death.

The tolerance of the brain to such injuries, when infection does not take place, is well illustrated by the next case.

III. *Open, comminuted, depressed fracture of the temporal bone (squamous portion) with laceration of the dura, and penetration of the brain.*

M. S., 32 years old, operated August 23, 1892, was struck, five weeks before, by a large iron pulley in the right temporal region. Through the external wound three depressed bits of bone were removed. The patient remained in a semi-comatose condition, with exacerbations and ameliorations, and a varying temperature, until seen by Dr. Thomas Reading, who at once summoned me. The next day the granulating wound was enlarged, after the usual anti-septic preparations; there was a *fungus cerebri* projecting through an opening in the dura, just above and behind the ear; the entire squamous portion of the temporal bone and the lower border of the parietal were splintered and depressed, being driven upward under the edge of the latter bone. Eleven fragments were removed, at least three of which penetrated the dura and punctured the brain.

Recovery was slow as regards the mental condition, though uneventful. Abscess was suspected, but apparently it is no longer to be feared. The wound, which was packed and left open, is healing nicely by granulation.

While this patient has practically recovered and is presented for examination, I fear that the inflammatory changes that have taken place must produce permanent brain impairment.

IV. *Closed, comminuted, depressed fracture of the temporal, sphenoid, and parietal bones ; extra-dural hæmorrhage.*

J. K., age 38, operated April 2, 1891, fell through an elevator shaft and was brought to the Hahnemann Hospital with a contusion of the right temporal fossa causing enormous swelling, ecchymosis of the right orbit, and profuse, persistent bleeding from the right nostril. The scalp was at once shaved, scrubbed, and covered with a wet bichloride cloth, the nose disinfected and packed with gauze, and an ice-bag applied to the eye. He had practically no symptoms, except that he seemed dazed and was considerably shocked, but in a few hours stupor and paralysis of the left side developed and intensified. No fracture could be made out on account of the enormous swelling, but, on incising the scalp, the whole temporal fossa was found depressed and comminuted, and portions of the squamous plate, parietal, and sphenoid were removed, from the external angular process to the occipital bone.

Under the bone was found an enormous clot which was carefully washed and picked away (not entirely however). The dura was intact, and, as there was no further hæmorrhage, the cavity was drained with iodoform gauze and the external wound closed with silk-worm gut.

Some cerebral excitement followed, but only lasted twenty-four hours, and he was discharged in two weeks cured. He is here for examination.

The difficulty of making out a fracture through a bruised and boggy scalp is here exemplified, for, although the whole temporal fossa was crushed in, we could not say positively that there was depression until the scalp was laid open. The depression too, though extensive, produced no symptoms beyond those of so-called "concussion," until the characteristic picture of meningeal hæmorrhage developed.

I am inclined to doubt the advisability of leaving a portion of the clot, instead of removing it all and tying the bleeding points. The clot however extended so far down that it would have been hard to catch a bleeding vessel, pressure was abundantly relieved, the dura was intact, free drainage was provided, and I felt pretty sure of my asepsis. The result was all that could be desired.

V. *Laceration of the brain and probable fracture of the base ; sub-dural hæmorrhage.*

Mrs. A. D., an elderly lady, patient of Dr. Pampinelli, fell down a long flight of stairs, striking the left side of the head on a stone pavement. When seen, immediately after the accident, by the Doctor, she was conscious and presented the usual symptoms of so-called

"concussion." About two hours later there gradually developed stupor, followed by deep coma and stertor, and complete paralysis of the right side. I saw her some ten hours after the accident and operated at once. A large semicircular flap of the scalp was raised, exposing the whole temporal fossa, the region of the bruise. A one-inch trephine was applied over and in front of the ear, on a level with the external angular process, and the inner surface of the skull explored with a negative result. The dura bulged prominently and looked dark, and, guided by this, the bony opening was freely enlarged downward and backward, the membrane incised, and a large clot washed out, which extended to the base in the middle fossa. There being no further bleeding, the dura was partially closed with catgut, leaving room for an iodoform gauze drain, and the outer wound similarly treated with a buried suture.

Movements on the right side showed themselves at once, but the patient remained comatose, and sank and died the next day.

I felt the responsibility of opening an intact skull, in this instance, very keenly, especially as a member of the family, who objected to the operation, stood by ready to wreak vengeance on the surgeon if he did not demonstrate a lesion. The skull was opened at the point named with a view of going forward to arrest a hæmorrhage from the middle meningeal, or backward and upward to relieve pressure in the region of the Rolandic fissure.

VI. *Closed, fissured fracture of the temporal (squamous portion), with depressed splinter of the inner plate ; serous apoplexy.*

G. C., 24 years old, operated April 5, 1892. Fell twenty feet from a crane, striking his right shoulder and the right side of his head. When brought to the Hahnemann Hospital he was much shocked, requiring stimulation with ammonia ; unconscious, could not be aroused, but winced when the bruise in the right temporal region was pressed on ; the reflexes on the right side were exaggerated, those on the left diminished ; the pupils reacted to light, and he vomited several times. The temporal fossa was laid bare, exposing a small fissure which ran from below upward into the squamoparietal suture. On removing a one-inch button, a splinter from the under surface was withdrawn from the dura into which it had been driven. This membrane bulged into the wound and was incised ; a quantity of fluid was evacuated, the flow keeping up several days, and requiring frequent change of the dressings. There was nothing else abnormal.

Improvement came gradually, consciousness returning on the second day ; restlessness and impaired power on the left side continuing several days longer, and irritative symptoms reappearing on several occasions. The wound healed kindly, and he was discharged at the end of six weeks. He is here for examination.

While the recovery here has been quite satisfactory, and the operation saved life, the extensive shaking up and laceration of the brain will be felt for a long time. Although mentally sluggish before the injury, I do not think he is back to the normal in this respect, but he is steadily improving.

The importance of an outlet for the relief of pressure is well shown by this case, as well as the necessity of going through a fissure to make sure there is not a splintering of the inner plate.

I well remember a case, seen some years ago, of a man who had fallen some distance, striking the top of his head. There was an extensive bruise on both sides, but no external fracture; deep coma and complete paralysis, one foot showing the faintest sensation. The inner plate was splintered on this side producing an enormous hæmorrhage. In such cases, the slightest localizing symptom may be of the greatest value.

VII. *Closed, fissured fracture of the frontal (vertical and orbital portions, external plate); open, comminuted fracture of the inner plate (frontal sinus); and of the ethmoid (horizontal plate); laceration of the dura and brain.*

G. S., 21 years old, fell twenty-five feet through an elevator shaft, striking the left supraorbital region on the edge of a block of stone. As luck would have it, the right eye was a glass one. He was admitted to the Hahnemann Hospital, February, 20, 1892. There was a contusion over the left eyebrow, but no fracture could be made out; persistent and profuse bleeding from the nose; extensive œdema and ecchymosis of the upper lid; chemosis, complete loss of vision even to bright light, with good motion of the eyeball, clear media, and a fixed, dilated pupil. There was no paralysis, the tendon reflexes being exaggerated on both sides, and the mental condition one of semi-stupidity, which increased. Besides, the left radius was broken, the right wrist and middle finger dislocated, and the iliac crest badly bruised.

A flap was raised, following, for cosmetic reasons, the line of the eyebrow, and curving upward in the temporal fossa; a linear fracture was found, running upward from the middle of the supraorbital arch for two inches, and backward along the roof of the orbit toward the optic foramen. There was no displacement. A three-quarter-inch trephine was applied at the upper end of the fissure, the removal of the button exposing an extensive comminution of the inner wall of the frontal sinus and the horizontal plate of the ethmoid. The dura was torn, as well as the anterior lobe of the brain. After removing all loose bits of bone, and disinfecting the nose, a drainage-tube was passed through the cribriform plate and out of the left nostril (Allis). The nose was tightly packed, the external wound sutured with silk-worm gut and drained with a strip of iodo-

form gauze which was brought out behind the external angular process. The wound healing was all that could be desired, his condition improving at once, and he recovered his eyesight, completely and suddenly, on the eleventh day. Subsequent observation has shown progressive atrophy of the optic nerve with diminished vision, but, of late, while the nerve-changes are present, his sight has improved to a wonderful degree ($\frac{1}{100}$ to $\frac{1}{30}$). Otherwise his health is good, and he is presented for examination.

Fractures of the optic foramen are sufficiently rare to be recorded, there being only about eighty reported in medical literature, and the sudden recovery of vision, as well as its recent improvement are unusual.

The very extensive comminution of the internal plate was out of all proportion as compared with the fissure in the external plate, fractures in this region deserving particular attention on this account and because, though closed externally, they are open internally through their communication with the nose and the frontal sinus.

In a case presenting a similar but less marked mental condition, with exaggerated reflexes, the diagnosis was made from the fact that, while there was a contusion and a small wound of the forehead, progressive ecchymosis of the upper lid appeared. Trephining showed an almost identical fracture with more extensive brain laceration.

VIII. *Open, comminuted fracture of the frontal bone; fissured fracture of the ethmoid (cribriform plate).*

J. M., 21 years of age, fell down a flight of cellar steps, striking his head against a stone floor. Was considerably dazed, but walked to the Hahnemann Hospital Dispensary where he was examined with the following result:

Patient is dull and drowsy; will answer questions, but lapses at once into his former apathetic condition; no paralyses or exalted reflexes. Over the right eyebrow is a ragged, contused wound about an inch and a half long, which leads down to comminuted bone; there is free and persistent epistaxis.

He was at once admitted to the Hospital, etherized, the field of operation shaved and cleansed, and the wound freely enlarged. After picking away the comminuted anterior wall of the frontal sinus, it was found that the posterior wall was more extensively fractured, and that the anterior lobe of the brain was exposed, the dura, however, being, fortunately, intact. A three-quarter inch trephine was applied, just above the sinus, and the sharp edges of the fracture bitten off with Rongeur forceps. The horizontal plate of the ethmoid was also found to be fissured. After a scrupulous cleansing, iodoform gauze was lightly packed in as a drain, and the wound

closed with a sub-cuticular, continuous suture of catgut. The nose too was disinfected.

Recovery was rapid and uneventful, and he was discharged at the end of ten days. This patient has gone to Ireland, but is reported perfectly well.

In this case disinfection and occlusion would not have prevented infection, which would have taken place through the nose and sinus. It shows the importance of enlarging an opening in the outer plate to ascertain the condition of the inner.

I would submit the following propositions and trust that some of them may merit discussion :

1. All contusions of the head should be examined most thoroughly and observed subsequently, no matter how slight the blow. This is particularly important when the injury is in the temporal region or forehead, the bone being thin in the former, and fractures being open internally in the latter location.

2. All scalp wounds should be viewed with suspicion. The head should be thoroughly scrubbed for some distance in every direction, and shaved if necessary, the wound scrupulously disinfected, and, unless very superficial, enlarged and deepened so as to allow an *inspection* of the skull. With the wound treatment of to-day there is no increase of danger from such a step, which saves many a life.

3. Loss of consciousness should always be looked upon as due to a possible head injury, if there is the barest chance of such having taken place, even in the presence of alcoholism, uræmia, opium poisoning, or apoplexy.

4. In the presence of brain symptoms, that is, exaltation or depression of mental, sensory, or motor functions, which are not steadily improving, where an injury has been inflicted, the skull should be explored. The guide to such an exploration may be the signs of an injury, a wound or a bruise, or, what is still more reliable, localizing symptoms. So too should the skull and then the dura, if necessary, be opened and their contents explored. The dangers are *nil* in laying bare the bone, slightly increased by trephining, only sufficient to cause hesitation when the dura is opened, and still greater when the brain is incised.

5. Trephining is done to remove pressure and irritants, to prevent sepsis, and, what is not sufficiently emphasized, to relieve tension. The sooner it is done the better, the mortality of primary or early operations being as one to thirty when compared with secondary or late ones (Wagner).

6. In a general way all fractures *that can be made out* should be trephined, whether brain symptoms are present or not.

But to explain :

All punctured fractures must be trephined.

All depressed fractures should be trephined ; if open, of course ; if closed, on account of the almost inevitable subsequent evils.

All fissured fractures should be trephined ; if closed and causing no symptoms, they cannot be made out. Once visible they require most thorough disinfection, and trephining or chiselling of, at least, the outer plate. They belong to the most dangerous and treacherous class of lesions.

7. In fractures of the base the whole head should be most carefully examined for lesions. Orifices through which infection may enter, such as the nose and ear, should be scrupulously cleaned and occluded, but such occlusion should not dam back discharges. If accessible lesions or localizing symptoms are made out, trephining is, of course, called for.

A word regarding the operative technique :

It is usually safer and as cosmetic to shave the whole scalp before operations on the skull.

Mechanical disinfection is accomplished by vigorous scrubbing with a stiff brush and potash soap, supplemented by ether, to get away the masses of epithelium glued together by sebum and sweat. Then alone can chemical purification be of value, and it is accomplished by scrubbing and prolonged contact with sublimate (1 to 2000).

Flaps should be formed with a view to affording subsequent drainage and to avoid deforming scars. They include all the tissues down to the bone.

Hæmorrhage is arrested by clipping the entire thickness of the scalp, tying or throwing a suture around any freely bleeding points at the close of the operation. The Esmarch band is unnecessary.

The most easily handled trephine is one of three-quarters or one inch diameter. Roberts's instrument is the one most easily kept clean. The opening can be quickly enlarged with the Rongeur or gnawing forceps.

The inner surface of the skull can be explored for quite a distance with the dural separator, and the sinuses detached from the bone with the same instrument.

The dura is, of course, opened at a little distance from the edge of the bony aperture to facilitate subsequent suture with catgut.

Its interior is examined by the finger which presses the brain out of the way, while the substance of the latter is entered with a grooved director or knife. Clean cut wounds of the brain heal kindly and are not followed by epilepsy, whereas tears or bruises notoriously produce the opposite results.

Hæmorrhage from the meningeal vessels can be reached by biting away the bone, and arrested by a stitch of catgut; that from a sinus, with hæmostats, which are left in place by ligature, suture, or, in certain localities, by packing. Bleeding from the exceedingly friable vessels of the pia is best treated by pressure, heat, or, rarely, by a very carefully applied ligature.

For drainage I have employed iodoform gauze; it should be remembered that it has two uses, to make pressure when packed tightly, and as a capillary drain when put in loosely.

To close the scalp wound I prefer silkworm-gut or catgut. The former is not apt to be followed by stitch abscesses from infection by the hair follicles, and these can be avoided by using the latter as a buried suture. I cannot speak too highly of the results obtained wherever I have used this subcutaneous method.

Dressings scarcely need mention. Aristol, or iodoform (1), boric acid (3), and sublimate (1 to 500) are dusted over the wound, cavities being packed with iodoform gauze. Occlusion and absorption are obtained by an abundance of gauze, absolutely sterile, or *fresh* from an antiseptic solution. This is changed or more added as soon as discharges come through, and before decomposition sets in.

THE FOURTH STAGE OF LABOR.

BY GEORGE WILLIAM WINTERBURN, PHAR. D., M.D., NEW YORK.

(Read before the Homœopathic Medical Society of the State of New York, October 5, 1892).

THE subject of the laceration of the perinæum, and its repair, is one of much importance if, as has been claimed, few women escape this accident of childbirth. The three stages of labor have long been classic, but if there indeed be few women who pass through this ordeal without damage, then the attention they should receive after the birth of the placenta may well be dignified with the title of the fourth stage. It is perhaps owing to the fact of the non-recognition of the necessity of this attention which leaves so many women to

suffer from an unrepaired rupture. The student is ordinarily taught that there are three stages of labor. Having secured the placenta he feels that his work is done. If he could be made to understand that his responsibility did not end here, that it was his duty to know just what was the actual condition of the vagina and uterus after the birth of the placenta, and that even a small laceration might be productive of serious immediate danger, and of long continued suffering to his patient, a great advance in the practical application of our art would have been made. It is this careful supervision of the parturient canal immediately after it has been emptied of its contents to which I would apply the title the Fourth Stage of Labor. And I do this with no desire to be eccentric, but because it seems to me its importance has been hitherto ignored. This abrasion and disfigurement of the parturient canal has been treated as an accidental thing, which it indeed truly is; but an accident which happens so frequently as to be almost a matter of course deserves rectification in a methodical manner. To dignify this procedure, then, with the title of the Fourth Stage will not, I hope, appear to give it more prominence than it deserves.

Let us then presuppose that the placenta has been delivered and disposed of satisfactorily. What then is the duty of the obstetrician to the woman in the case? He should, after allowing her a reasonable time for rest, say fifteen minutes or so, have every particle of soiled clothing removed, and her person gently but thoroughly cleansed. This will not be done unless he oversees the job personally. The ideas of the ordinary nurse as to cleanliness are very much like those of the man who takes a bath once a week—in his best estate he is never clean.

If the bed has been prepared, and the woman's own clothing adjusted in a proper manner at the onset of labor, the soiled linen can be removed deftly and easily. Should the labor have come on suddenly, or the opportunity to make these preparations been neglected, the condition of the bed and of the patient's body linen will be much worse, but this only makes the change the more imperative. Every particle of soil and dampness must be removed, the clean sheets, night-dress and napkins thoroughly baked and put on while yet quite warm. If they can have previously been hung outdoors in the direct sunlight for some hours, so much the better. The external genitals, abdomen and thighs of the patient should be cleansed with water which has been boiled and has cooled to a temperature of 115° Fahr. This cleansing should be done with as little expo-

sure to the air as possible; the surfaces which have been wetted being then rubbed with hot alcohol (alcohol, 1; aqua bull., 2). This whole process of changing the linen and bathing should not occupy more than ten minutes' time, everything having been prepared during the moments the woman is resting. If the toilet is prolonged, the patient is exhausted unnecessarily.

The patient being now comfortable and clean, the doctor should proceed to examine carefully the condition of the uterus, vagina and perinæum. If there has been laceration of the cervix it may usually be treated on the expectant plan, though if the edges gape apart a stitch or two, which brings the freshly torn surfaces in apposition, will do no harm, and are not troublesome to put in. Still a tear, which looks quite serious at the time, will often completely disappear during the process of involution without any treatment at all. Nor should it be overlooked that free drainage from the uterine cavity is a most important factor in normal convalescence, which must not be interfered with by the results of the operation. I am not, therefore, prepared to recommend immediate repair of the cervix to the practitioner inexperienced in operative procedure, though believing that in skilful hands it is a wise measure.

Laceration of the vagina is apt to be more serious, in both immediate and remote consequences, and these lacerations are almost always overlooked. They should be carefully searched for and repaired. The bruised and congested appearance of the tissues immediately after labor make it difficult to decide upon the existence or non-existence of a laceration. The trained finger will learn to detect them by the roughness and irregularity of the surface in the tear; but, at first, the practitioner will have to depend upon eyesight, and will need to so place the patient as to get the benefit of a strong direct light. By drying the surface with a bit of borated cotton, the roughened appearance will indicate the location of the tear. But he will usually be greatly surprised at the extent of the injury, if he will seize the edges of the wound with forceps and draw them gently apart. If the wound is superficial, and does not involve the perineal body, a few catgut sutures will be all that is required. Not infrequently, however, the perineal body is injured, even when the commissure remains intact.

While these rents in the vagina are of much importance, those of the outlet are no less so. These latter do not usually involve the perineal body, but are confined to the mucous and submucous tissues, which overlay it. It is quite important that these rents should be at

once repaired, if they extend beyond the fourchette. Unfortunately, this is not done in most cases. Practitioners are too ready to believe that nature will take care of the case. But unless the edges of the wound are carefully coapted, the only healing that can take place is by granulation, and this leaves a weakened structure, ready to break down again at the culmination of the next pregnancy. It is these cases in which rupture has supervened on rupture which are apt to cause such serious derangement of health in after-life. If properly treated there is neither loss of substance nor weakening of tissue, and the parts are as firm and as useful as before.

In the more serious lacerations, where the fibres of the perineal body are torn apart, or even the sphincter ani and rectum involved, the need of immediate repair is equally obvious. There may be circumstances in which delay is advantageous, but these are the exceptions. The more serious operations may be delayed in order to give time for the woman to react from the depression of a long-lasting labor, or in order to obtain efficient assistance or other desirable conditions. Such a delay of twelve hours, or even a day or two when necessary, does not take the operation out of the category of primary.

The primary operation for perineorrhaphy is much less formidable than the secondary, and has this decided advantage to the patient, that, when properly performed, subsequent parturition is less likely to cause a new rupture. The secondary operation is very apt to diminish the size of the vulva considerably, owing to the atrophy of the tissues during the months before the delayed operation, and the necessity of destroying tissue in order to obtain the freshened surfaces required. The narrowing of the vulva is, to be sure, an operative fault, but unless the surgeon is very skillful, he will either do this or fail to secure a functionally perfect perinæum. It is not at all uncommon to see women whose perinæi have the appearance of being perfectly restored, who yet have but slight control of the perineal muscles. The superficial tissues have healed, but the muscle itself has remained divided. The results are analogous to those by no means infrequent cases of concealed rupture where the perineal body has given way but the mucous covering has remained intact.

Of the various methods which have been devised for the repair of the injured perinæum, it may be truly said that each has shown good results, and they may, therefore, all be said to be good. While the main question is as to the means by which the best final result

may be secured, yet in the primary operation preference should especially be given to that method which requires the fewest assistants, the least elaborate preparation, and occupies the shortest space of time.

Although I advise that every lesion of the parturient canal should be repaired at once, whenever this is possible, I by no means deny that spontaneous cicatrization is possible even when the injury is considerable. Tarnier, Pajot, Pozzi, Guéniot, and others, have observed and commented on such cases, and in my own experience I have had knowledge of cases in which the power of the system to obliterate the evidences of a laceration have been unmistakable. Under good homœopathic medication, also, much may be done, and I am by no means as skeptical of the efficiency of this mode of treatment as most surgeons are. Yet in no one given case have we reason to expect so fortunate a termination of the accident, while even moderate skill can ensure, when aided by proper attention to the general health, a completely satisfactory result.

This is not the place for primary instruction in the methods of repair, and no one is justified in making the operation unless he has seen it done by a competent surgeon, and understands the principles of its technique. There are, however, a few suggestions which may properly find place here.

First, find out the exact state of the tissues. The wound is usually much larger than it appears to be. Carefully drying the surface and seizing the four corners of the wound with forceps, the edges may be drawn apart and the true nature of the wound disclosed. Repair must take place from below, the success of the operation depending upon coapting the torn muscular fibres. The nature of the tear will indicate the direction of the stitches, which must be put in with only moderate tension—just sufficient to draw the fibres into place. The torn surfaces must not be pressed together tightly, or their vitality will be injured. It must not be forgotten that the parts will, in a day or so, become greatly swollen, and the wounded surfaces should have an equal chance to expand with the contiguous tissues. In this way union by first intention can almost certainly be secured. For the deeper sutures silkworm-gut possesses many advantages over silver wire. They should be tied as inserted. The superficial sutures should be cat-gut. These are needed to insure perfect coaptation of the skin and mucous surfaces. These latter will be absorbed and need no attention; the deeper ones are removed on the fourteenth day.

The common error in repairing severe but incomplete laceration is to treat it as a longitudinal tear of the posterior vaginal wall, when as a matter of fact it is usually a transverse tear at right angle with and immediately within the orifice. This more frequent form of laceration is occasioned by the outward and forward extension of the perinaeum as it is stretched by the advancing head, and begins as a rupture of the fibrous attachments between the levator ani and the submucous tissue. The contraction of the muscles causes a retraction of the upper (vaginal) portion of the involved tissues, resulting in the production of an irregular raw surface. This on inspection looks and feels like a longitudinal tear; but if the upper portion is seized in the median line with a pair of dressing forceps, and drawn forward and downward its true form will be perceived.

But such a simple transverse laceration of the attachments of the levator ani and other muscles from the muscles themselves is rarely seen. Generally this is complicated by the extension of one or both of its outer extremities upward along the vaginal wall, caused by the splitting apart of the fibres of the levator ani in the direction of their length.

In this particular form of laceration, which, as it does not involve the commissure, is so frequently overlooked by the "busy practitioner," I use the following simple procedure. It has the advantage that it can be done without anæsthesia, and with the sole aid of an ordinary nurse; but it can only be done immediately at the conclusion of labor and while the parts are yet benumbed, and the muscles have not firmly retracted. An extra large, fully curved needle should be used. This is made to enter through the skin just in front of the anus, and three-quarters of an inch from the median line, and, guided by a finger in the rectum, is carried directly upward in the recto-vaginal septum, about an inch or more, into the upper portion of the perineal body, and swept downward to correspond on the other side of the median line. The sutures should be buried throughout their whole length, that is they must not show in the wound. If they do, it will be necessary to supplement them with a row of superficial stitches (continuous catgut) in the vagina. A second suture follows the first, in parallel, about one-third of an inch in front. From three to five such sutures will be needed. The external sutures are first put in but not tied. Then the vaginal ones, if these are necessary. These latter are secured properly and then the primary ones, in the inverse order of their introduction, are tied over a roll of gauze, care being taken to free the wound of clots before finally closing it.

In conclusion, while reiterating the statement already made that all lacerations of the parturient canal should, if the obstetrician is competent to undertake that class of work, be immediately repaired, I would enter a protest against that kind of midwifery which permits such lacerations. It is a disgrace to the obstetrical science of the day that any considerable portion of our cases fare so badly at our hands. Laceration is evidence of carelessness or incompetency if it occur often in any man's practice. Not every man who studies medicine can make of himself a skilful obstetrician. Most practitioners dislike midwifery, and only practice it because it seems a necessary adjunct to family practice. Any one who approaches any class of work in that spirit will fail to achieve the best results. Enthusiasm is the key which unlocks the door of success, and in midwifery this is eminently so.

I have recently discussed before the medical society of a neighboring State the relation of the perinæum to normal labor from the standpoint of the evolutionist. The argument in favor of the natural stability of that organ seems to me complete. The subject, however, is too important to be more than alluded to in this place, but I beg leave to append, as an expression of my matured opinion, the paper in which this is discussed.*

APHTHÆ.

BY J. L. FERSON, M.D., PITTSBURGH, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

APIITHÆ are ulcerations of the follicles of the buccal cavity, resulting from an inflamed condition, which owes its origin to some derangement of the digestive apparatus.

Dr. A. M. Cushing, in the American Institute *Proceedings* for 1880, ascribes their presence to debility, due very often to too frequent bathing. Aphthæ may develop in persons of any age, but we are only concerned at present with the affection in the mouths of children.

In the *Homœopathic Recorder* of 1891, page 271, the interesting

* Dr. Winterburn, No. 230 West 132d Street, New York, will send a copy of this paper to any reader of the HAHNEMANNIAN MONTHLY who may desire it.

result of observations made by Dr. Baum at the Midwife Institute in Appeln is given as follows: Suspecting that the development of aphthæ in new-born infants was due to the cleansing of their mouths just after birth, he first had the mouths of forty infants carefully and thoroughly cleaned just after birth and after each nursing. Of the forty only eight escaped without aphthæ. In nearly every case the trouble developed within two days, some even before the children were placed at the breast.

Following this with one hundred and seventy infants, any attempt to clean the mouths was strictly forbidden, and among this number only one case developed, and in this case, it was afterwards learned, the nurse had disobeyed orders and cleaned the infant's mouth.

With aphthæ any and all parts of the buccal cavity may be involved and the glands lying contiguous; the soft parts may be involved to the extent of swelling and inflammation. The presence of aphthæ in the mouth of the infant suffering with intestinal derangements, which have debilitated it and interfered with its nutrition, marks a serious progress of the disease, which demands the most careful selection of a remedy.

In the early stage of development aphthæ may resemble thrush. There may be a similar exudation, but in thrush the removal of the exudation shows the mucous membrane intact but inflamed, while with aphthæ it reveals a bleeding, ulcerated surface. Simple washes of water, mild salt water, or molasses, entirely for the purpose of cleanliness, or a wash made of the indicated remedy in water, are commendable; but our sole reliance for the cure of the patient, aside from dietetic and hygienic measures, must be the similar remedy.

REMEDIES.

Arsenicum.—When aphthæ become livid or bluish, the gums livid and bleeding.

Borax.—Aphthæ cheesy in character and color, more often found on the inner surface of the cheeks, although also on tongue and fauces. They bleed easily. The mucous membrane of the fore part of the palate looks dry and wrinkled as if burnt. The mouth is very hot, noticeable to mother when child nurses, and the membranes are dry.

Hellebore.—Ulcers flat, yellow, with elevated gray edges, or with red, swollen base, scattered over gums, tongue and mouth. The mouth may be dry, or there may be a very offensive, profuse saliva.

The glands of the neck and under the chin are swollen. There are blisters around the mouth.

Kali Chloricum (K.Cl.O_3).—The mucous surfaces of the mouth are red and tumid. There are ulcers symmetrical in outline, with gray base, on cheeks, lips and tongue. Two symmetrical ulcers on the sides of the tongue. The tongue is coated white in the middle and at the base. Salivation, the saliva being acid, tough, stringy.

Mercurius Viv.—The mucous membrane is white, sore and swollen. The gums white, spongy, scorbutic. The ulcers are flat, white and superficial. Saliva profuse, ropy, fœtid. The glands of the neck and about the lower jaw swollen.

Muriatic Acid.—Ulcers large, irregular in outline and very deep, bluish or black base, with dark edges. Accumulation of much insipid mucus glues up the mouth, or there is profuse saliva, with fœtid odor from mouth. Salivary glands swollen and tender.

Nitric Acid.—Swelling and redness of the mucous membranes of the mouth and gums. Ulcers irregular in outline, deep and white or else filled with excessive granulations. Ulcers extend to lips, chin and cheeks. Tongue coated green, saliva bloody, offensive, acrid.

Sulphuric Acid.—Entire inner mouth ulcerated. Mouth and tongue filled with blisters. Ulcers are irregular in outline and of yellow color. Saliva free. Breath very offensive, gums yellowish-white.

THE CAUSES OF SUFFERING AT THE CLIMACTERIC PERIOD.*

BY B. FRANK BETTS, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

THE rapid development of the healthy female at puberty, without suffering or serious inconvenience, affords a striking illustration of nature's ability to meet the requirements necessary to prepare her for her divinely appointed mission of maternity. And we believe that the same ability exists to pilot her safely to her haven of rest after she has reared a family and arrived at a period of life at which procreation must cease.

* Submitted by request.

Good health and proper environments should secure immunity from serious physical suffering during the trying ordeals consequent upon gestation, parturition, and the cessation of the menstrual function. Yet from the remotest period in history to the present time, and amongst all classes physical suffering has been so common as to be considered as a necessary part of these physiological processes.

Reason, however, rebels at the thought that grave systemic disturbances are to be coupled with the performance of normal functional action, and whilst the actual cessation of the procreative activity may leave the reserve life-force a little overbalanced for a time, the account should soon be adjusted by proper treatment. And all things should go on as harmoniously as ever. It is only when nature's efforts are thwarted and impediments are thrust in her way that she protests and suffering ensues.

Whilst this is frequently the case, I repeat, it is not the necessary concomitant of the change and suffering at this time is as truly indicative of disease as it is at any other, and should claim our careful consideration for its relief.

It is not every child's life that is threatened at the time of dentition. It is not every woman that is confronted with serious danger during gestation, and it is not every one that has to suffer at the change of life. Everything conducive to good health diminishes the dangers and discomforts at these periods. Close attention should be paid to the diet of climacteric patients. The nervous, or neurasthenic should subsist almost if not exclusively upon vegetable food—and all climacteric patients are better off without much meat. The stout and plethoric do not need it, but require plenty of fruit to promote regular alvine evacuations. The nervous and weak will be benefited by gluten preparations, gluten wafers, with unfermented wine or grape juice, but these are not such as suffer the most from the cessation of the menstrual flow.

Exercise is an important factor to be considered in the treatment of the climacteric and attention to the action of the skin is quite as necessary. The copious sweats suggest the cold sponge bath in the morning following by vigorous rubbing. Considerable suffering is induced by renal insufficiency. In such cases more than the usual attention is to be paid to the diet and with a healthy condition of the skin the emunctory may be able to ward off serious complications.

To renal insufficiency with constipation we can attribute much of the headache, sleeplessness, etc., so frequently complained of at this

time of life. The use of coffee as well as all other stimulants must be stopped. Tea is to be preferred as it promotes cutaneous transpiration but this beverage must be used sparingly.

Sleep at proper times so as not to interfere with exercise is very important. The exacting demands of society cannot be comfortably met at the climacteric.

There are sources of suffering, however, besides these dependent upon imperfective functionalism of the emunctories. These are purely local, and are often the result of previous injuries to the reproductive organs sustained at parturition, or arise from the development of new growths within the uterus.

These conditions are so frequently met with, that I desire to lay especial stress upon them at this time, and urge an examination, carefully made, whenever the symptoms do not speedily disappear from the administration of medicine and careful attention to the laws of health just alluded to.

So many of the symptoms of serious pelvic disease are dismissed by physicians with the assurance that they will disappear and all will be well after the change, that this advice seems to be especially necessary at this time, for without it many patients wait in vain until their application for relief comes too late.

When an examination is made, we often find that an incomplete laceration of the perinæum is causing the rectal and vesical walls, already weakened by the atrophic process of the menopause, to become prolapsed, so that constipation is aggravated from the development of rectocele, and a cystocele prevents a perfect evacuation of the bladder. These, in turn, tend to induce prolapsus uteri and complete protrusion or procidentia later in life. In such cases the hot flushes, the critical sweats, and the nervous phenomena of the climacteric are all very much aggravated.

There is no part of the genital tract in closer sympathy with the nerve centres than the uterine cervix. If it is diseased or disorganized, an impression is conveyed to the nervous system, causing not only severe gastric disturbances, dyspepsia and its train of ills, but also functional disturbances in the brain and spinal cord, inducing numbness, muscular twitchings, and formication, as well as such an impairment of the intellectual faculties as to cause melancholy, irritability of temper, or even insanity.

If we find a laceration of the cervix of long standing, we can very readily understand how such a source of irritation can impair the general health; for we do not overlook the fact that it may have

imprisoned within its tissues diseased nerve filaments which produce a profound impression upon both the ganglionic nervous system and the cerebro-spinal axis.

Patients on the verge of insanity have been restored to perfect health by cutting away all this hard cicatricial tissue upon the edges and within the cleft of old lacerations. In some cases a displacement will require to be corrected or an erosion of the cervix will have to be healed by the application of iodized phenol, cleansing vaginal injections, and the suitable homœopathic remedy. Vaginitis, resulting from a trickling of urine into the vaginal passage during the night when there is partial incontinence, should not be overlooked as a source of reflex nervous distress.

Evidences of cancer are sought for early in those cases in which the menses continue to recur too frequently or are too profuse. It will be remembered that this disease is especially liable to occur at this time, and that an early resort to the knife is the only means for prolonging life or relieving suffering.

A stenosis of the cervical canal, after a cessation of the menses, induces epigastric distress and general discomfort, and can be opened by the passage of the uterine sound, or in some cases it will need to be incised.

After a previous operation for the repair of a lacerated cervix the atrophic process may cause such a diminution in the calibre of the canal as to make it necessary to open it by bi-lateral incisions to a slight extent so as to permit the passage of instruments and the discharge of pent-up secretions. The remedies most frequently required are the following, viz. :

Sulph.—For the hot flashes of heat, when considerable prostration follows or they are succeeded by cold perspiration or a hungry feeling. The skin is dry; the bowels are constipated; there is no desire for food in the morning but hunger at 11 or 12 o'clock. The patient is irritable or melancholy; with anxiety about her salvation; often feels suffocated and must go to the open window or door for fresh air.

Sulph. ac.—Flushes of heat with perspiration, or profuse perspiration on the upper part of the body only in debilitated women with prolapsus uteri or retroversion. They often complain of trembling in different parts of the body; it is an inward trembling, not visible externally. They have perverted sensations, as if a film was on the skin of the face. They want to do everything in a hurry, and are restless and nervous.

Lachesis.—Loquacious women with vertigo, heat in the vertex and

a bruised feeling in the hips, relieved by the flow, with flashes at night; they awaken feeling badly.

Sanguinaria.—Hot flashes of heat. Gastric disarrangements at the climacteric; burning heat in the region of the stomach; irregular action of the heart, with great weakness and soreness in the muscles of the neck and down the back.

Verat. alb.—Despondency at the climacteric. Cold sweats even in a warm room. Complains of being bathed in a cold sweat. Very nervous at the climacteric. Feels as if she must almost fly. Is very much constipated and depressed.

Actea rac.—Melancholy, low-spirited and nervous. Has headache on top of the head. Suspicious; thinks she will surely go crazy. Numbness in different parts of the body, arms, legs, etc. Bruised, sore feeling in the muscles.

Crocus.—Uterine hæmorrhage at time of menses. Blood dark and stringy, with sensation of movement in the abdomen.

Magnolia grandiflora has benefited patients who complained of mental and physical inability, lassitude of mind and body, leading to despondency, confusion, apprehension, and dulness of hearing.

SURGICAL CASES.

BY JAMES H. THOMPSON, M.D., PITTSBURGH, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

THE following are cases selected from my note-book, showing many points of interest; and I will endeavor to explain each case in a definite manner.

CASE I.—Mr. James F——, æt. 23, American, descendant of healthy parents, and private patient in Homœopathic Hospital, Pittsburgh, Pa. With the society's permission, I will give a short history of his suffering before entering the hospital.

In April, 1889, was summoned to visit a patient at one of our leading hotels, and who was reported to be in a dying condition. Upon my arrival, I quickly conceived the idea that the case was one demanding prompt action on the part of the attending physician to save his life from a horrible death, the result of a deadly poison. Symptoms of strychnine were so clearly manifested that it would be impossible for any keen observer to be mistaken in making a correct diagnosis.

The spasms were of the most violent kind ("tetanic in nature") following each other in rapid succession.

Twitching of the limbs, jaws rigid, and a marked case of opisthotonos; during the spasm, head was drawn back touching the heels.

With this terrible picture of suffering humanity before me, I began at once to relieve the patient by the use of emetics—chloroform and tannic acid.

In ten hours, all symptoms showed marked amelioration; but not until the fifth day did I feel assured that the patient would recover.

During my last visit I learned that the deadly poison had been taken by my patient to put an end to his sufferings—as he expressed it. Learning this, I questioned him closely as to the nature of his ill-health; he explained all in a few words, by calling my attention to his right arm, which was completely paralyzed, the result of an accident which happened about seven years before I met him.

When a lad, he visited the lumber regions of Virginia, and while at play removed a scotch from a log that was propped on a pair of trestles; then the log began to roll, and in making an attempt to stop it, caught his right arm through to the shoulder between the log and trestle, remaining in that position two hours before relieved, crushing the arm and shoulder-joint almost to a pulp.

The injury proved to be of a very serious nature, and for many weeks amputation seemed to be the only hope of saving life, to which he seriously objected.

Learning so much of his past history, I became more interested than ever, and kindly asked him to call at my office in two or three days, which he did, although he remarked previously that I could not help him after he had consulted all the eminent surgeons at home and abroad, each and every one having a different diagnosis and a fatal prognosis. The opinions of a few were, viz., tuberculosis of the shoulder-joint, osteoid cancer, lympho-sarcoma, necrosis, caries, lipomata, and one of the number whom he consulted called it an aneurism of the axillary artery. Amputation at the shoulder was the universal opinion. Upon his first visit to my office I had his clothing removed and began my examination. Objective symptoms were: Atrophy of all the muscles, inability to make the slightest motion of the arm (complete paralysis), slight enlargement about the joint and axilla. Closer examination showed two distinct growths, one solid and the other semi-solid with slight fluctuations; the semi-solid situated on line of the axillary artery, the solid one

extending around, forming a complete cap of the joint. Having arrived at my diagnosis, and predicting my prognosis, he at once acceded to the operation, granting me the right to amputate the arm if the growth could not be removed with safety.

Entered the hospital April 25, 1889. Being anaesthetized, I proceeded to explore by cutting down upon what I diagnosed as an enchondroma, complicated with an aneurism of the axillary artery—making two incisions, one parallel to the axilla, and one parallel to the posterior border of the deltoid. Dissecting up the soft tissues, I came down upon the hard fibrous growth, completely encapsulating, making a net-work of the soft tissue about the joint, the arteries and sinews passing direct through the solid mass, overlapping the aneurism which was about the size of a hen's egg, producing sufficient pressure to prevent its enlargement. Pressing the nerves to produce complete paralysis, I started to remove the fibrous mass without injury to the soft parts, when I accidentally ruptured the aneurism sac, the blood spurting in all directions, but in a second caught the rent and the greater part of the sac with my forceps; then I ligated the mass with a heavy silk thread. Being free of the aneurism, proceeded to make a clean dissection of the fibrous mass, which seemed to be attached to a rent in the capsular ligament, and succeeded in removing it without injuring any of the more delicate tissue except the accident mentioned above. Cleansed the wound by irrigating with a bichloride solution 1000, inserted drainage-tube, closing with silk sutures. Applied the combined dressing, and had him removed to his room to await further results. Rallied nicely from the operation; temperature showed no signs of elevation before the ninth day. I removed the dressing and found considerable discharge of a good healthy character; wound being redressed each day for the first week, then every other day, until all healed nicely in about three weeks. At no time did the temperature go above 100°. The full use of the hand and arm was completely restored at the end of the fourth week. I met him about two weeks ago enjoying the best of health; examined arm closely, and found no trace either of the fibrous mass or aneurism. In conclusion, the above case proved to be an obscure one of paralysis of the right arm due to an enchondroma of the shoulder-joint, and an aneurism of the axillary artery.

CASE II.—*Abscess of the Brain*.—Mr. John G., æt. 20, American, private patient in homœopathic hospital during June, 1889.

He sustained what was then supposed to be nothing more than a

lacerated wound of the scalp, over the left frontal eminence, caused by running against an iron beam. The blow not being of sufficient force to disturb the equilibrium, he discarded the idea of anything of a serious character (although immediately after he had a slight hæmorrhage); nevertheless, he applied a light dressing and went about his work as usual. He continued in that condition for ten days, or two weeks, when he began to suffer with chills, fever, headache, dizziness, and at times vomiting. Consulted me as to its cause; upon my first visit found all the symptoms mentioned above but greatly aggravated, with an elevation of temperature, the wound being completely healed at this time.

Thoroughly cleansing the seat of injury, opened through the scalp, and with probe failed to detect any sign of a fracture or puncture of the outer table of the cranium. Redressed it, advising him to remain quietly at home and await further developments. I called again in three days, but found no improvement; there was a slight rise in temperature, vomiting, extremely weak and slow pulse, respiration reduced to twelve per minute.

At no time unconscious.

Diagnosed: Abscess of the brain, due to the injuries received some three weeks previous; advised an operation. Had him removed to the hospital, anæsthetized, made the usual crucial incision over the seat of injury, exposing the cranium; I found it slightly depressed, but no sign of fracture. Satisfied as to my diagnosis, proceeded to remove with the chisel a piece of the outer table about the size of a quarter dollar. Having removed the outer table, came down upon the middle one, which was greatly depressed and fractured; removing this with the same instrument, reached the inner table and found it in a similar condition. On reaching the membranes, found them to bulge from the opening through the cranial walls. Cutting through the membranes, a quantity of pus escaped with considerable force. Altogether, about four (4) ounces of pus were liberated from the interior of the cerebrum. A soft rubber drainage-tube was inserted four inches by measurement down into the cavity of the brain, and antiseptic dressing applied. Redressed each day for one week, irrigated freely with a bi-chloride solution $\frac{1}{1000}$. Immediate improvement took place in the patient's condition. The pulse and respiration increased in strength and rapidity, the pain soon disappeared, and the patient fully recovered within a month. It was remarkable, with the amount of pus producing pressure on the cerebrum; yet at no time did he show signs of unconsciousness.

Case II., which I diagnosed as an abscess of the brain, is to-day more frequently discussed by physicians, and the same time less definitely determined with regard to their cause and the treatment of their various forms; yet it is an example of what can be accomplished in apparently hopeless cases, and it is only five years since any deliberate and well-defined steps were taken in surgical operations on the brain. William MacEwen, M.D., performed the first operation in Glasgow, Scotland, nearly a dozen years ago. The case, I think, was not reported for a considerable time afterwards. In the year 1876 he was called to attend a boy who had been struck on the head, and in whose case there developed some months later symptoms of a lesion of the brain. He proposed an operation, not at the seat of the injury but over the fissure of Rolando.

The boy's friends would not consent to an operation and he died twenty-four hours later, then Dr. MacEwen was permitted to operate, as he would have done prior to death. Removing the button of bone, nothing was seen on the surface, but in plunging the scalpel into the brain substance an abscess was opened. In 1883, Dr. MacEwen performed the first operation of this kind on record. He trephined over the upper portion of the ascending parietal convolution and evacuated a quantity of serous fluid. The woman made a good recovery and enjoyed perfect health for some years. The case was reported in the early part of 1884 before the Pathological Society in Glasgow. No doubt the credit of the first operation in brain surgery belongs to Dr. MacEwen.

Among the many protrusions of the abdominal cavity probably none have attracted more attention than inguinal and femoral hernia. This is largely due to the fact that with our advanced knowledge of the human anatomy many points in the ætiology and causation have been cleared up, also our methods of treatment are more scientific and accurate. Operations for the different forms of hernia have been devised by removing the tumors and restoring the structure to its normal anatomical condition. Very often, when removing the deformity, other vital parts are injured, causing a new defect for the purpose of covering an old one. With the progress of abdominal surgery we began to apply different methods for the radical cure of hernia.

First, by cutting down upon the protrusion and replacing the tissue into the abdominal cavity, and closing the wound, to be healed by first intention.

Secondly, by cutting down, ligating and removing the sac, the

peritonæum being carefully drawn together with a continuous suture and permitted to heal by granulation.

Surgeons have devised different methods for treating the sac, but all have experienced this in common, namely, to obliterate the sac and permit the wound to heal by granulation.

The following cases go to illustrate what I have had in view :

CASE I.—Mr. H. K., æt. 34. In June, 1889, while at work in a warehouse packing furniture, he lost his hold and fell a distance of twenty feet, alighting on a spring mattress placed upon two trestles, his weight being sufficient to break the springs, and his left leg passed through up to the groin, producing a lacerated wound of the abdominal parietes of the left inguinal hypogastric region sufficient to completely disembowel him. The wound extended from the anterior superior spine of the ilium down to the symphysis pubes. The muscles were so badly lacerated that it was found impossible to draw them together with sutures. The viscera being replaced, the peritonæum caught up, closed by continuous sutures and packed with iodoform gauze. Permitted to heal by granulation. The wound being dressed antiseptically, was left untouched for five days, at which time there was a slight rise in temperature, the temperature at no time exceeding 101° . The wound was irrigated and dressed once a day until healthy granulation appeared, after which time the dressing was renewed every third day. It continued to heal without any new symptoms, and at the end of the seventh week it was completely healed. The patient had no occasion to wear any form of truss or abdominal support, and remaining perfectly well up to the present date.

CASE IV.—Mr. Richard G., æt. 24. In December, 1890, I was called to assist in reducing a complete inguinal hernia. The tumor was of an enormous size, extending down near the scrotum. All attempts to reduce it failed. Having been in this critical state four days, vomiting and all symptoms of approaching death, I advised an operation, to which he quickly consented. After having anæsthetized him, I cut down upon the tumor, which was found to be in a gangrened condition and contained a yellowish fluid. The sac was very adherent and the parts about the ring blended together by adhesions, whilst above there was a sac containing a large mass of omentum, which was adherent to its walls.

The omentum was ligated and cut off, also the sac was ligated and removed. Some of McBurney's rules in operations consists of cutting down on the sac, separating the different elements, and splitting

up the canal, ligating the sac very high, then cutting it away, uniting the skin to the pillar, and stuffing the wound with iodoform gauze.

January 5, 1891.—Patient discharged. Cicatrix firm. Examined March, 1892, and found the cicatrix firm, without any tendency to a return of the hernia. No form of a truss or abdominal supporter used. In all cases, then, there is a strong cicatricial band, and the use of a truss or any support produces absorption from the pressure and causes the new tissue to break down. If time and space would permit, I could report other cases of a similar nature which I treated with the same success.

In following McBurney's rules in operation I have never found a return of the hernia, so far as I can learn.

CLINICAL MEDICINE OF HOMŒOPATHY.

BY WILLIAM A. SEIBERT, M.D., EASTON, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
September 14, 1892.)

THE necessity of clean-cut definitions in science is manifestly foremost in the minds of scientific writers, evidenced by the fact that the first pages of practically all scientific studies are devoted to definitions. To everybody it is at once axiomatically apparent that all science is necessarily founded on concise definitions. The law of homœopathy, as the science of therapeutics, seems the first star of its kind permanently placed in the galaxy of sciences. We have a right to inquire whether we have not yet sufficiently recovered from the stunning blow by the falling apple, to allow us to carefully define the terms of our law to our students at the very beginning of the study of homœopathy. On first impression this assertion may seem "wild" because the law seems self-evident; yet that such is not actually the case is certain from the variety of definitions to "Homœopathic Physician" called out in the *Medical Era* some time ago. It seemed plainly evident that Dr. Gatchell felt then that concise definitions were needed to prevent some of the great and petty differences in our ranks; or that these differences were due simply to a little different conception of some fundamental definition that might lead even to a *reductio ad absurdum*; or, it may be, that we all comprehended the law and our differences amounted to mere dif-

ferences of opinion, and were quite foreign to the law of faith in which entitles to citizenship under its banner. The terms of the law need to be accurately comprehended before the law itself can possibly be fully comprehended. What can be classed under "similibus," and what is excluded, and how is this eligibility to be determined? What on the other hand are the "similia," and what are not? Uniform ideas regarding these terms at the outset would avoid differences of opinion which should not be ascribed to a law of nature. Furthermore, opinions, or differences of opinion, should not divide our ranks when subdivision merely is called for.

Clinical medicine, according to the latest dictionaries is "that part of medicine which is occupied with the investigation of diseases at the bedside." Clinical medicine of homœopathy, which is not defined in dictionaries, consists in the careful study of the symptomatology of disease at the bedside, the comparison of this symptomatology with the pathogenetic symptomatology of drugs, and finally the selection and application of the similimum. The difference between these definitions is the difference between empiricism and science, and our object is a brief consideration and analysis of this clinical medicine of homœopathy.

Pathogenetic symptomatology, the "similibus," is receiving the careful attention of our ablest homœopathic talent, and is being developed after a fashion quite becoming an accurate science. Consistently, the symptomatology of disease should be developed *pari passu*, and should receive equal attention from the foremost homœopathic talent. I say homœopathic talent advisedly because the "similia" is no less important than either term of a mathematical equation. The given term if inaccurately interpreted will, and must result in an inaccurate second term. A correct understanding of "similia" in every detail is equally or more important than a knowledge of "similibus." On investigation we think we can safely say, without fear of contradiction that the symptomatology of disease is not developed equally with the pathogenetic symptomatology of drugs.

Diagnosis of the disease does not constitute its "similia," though it is to this that many physicians pin their entire treatment, entirely forgetting the patient and his surroundings. Nor, as we understand it, does subjective investigation alone constitute the "similia." Symptomatology, according to the Century Dictionary, is the "*sum* of scientific knowledge concerning symptoms, also the *array* of symptoms presented by a disease" or drug effect. It is the *sum* of our

knowledge regarding the symptoms, individually and collectively: their careful subjective enumeration, regional consideration, diagnostic importance, their pathological and bacteriological as well as it may be only their physiological significance, at the risk of some redundant knowledge that may be eliminated later on if need be. Then, finally, it is the total *array* of these symptoms, due importance being given to each, that gives us the scientifically accurate first term of our law, and completes the first proposition in the definition of clinical medicine of homœopathy.

The comparison of this totality of symptoms with the pathogenetic symptomatology constitutes the second step of this scientific process. The "*similibus*," as before intimated, is receiving the attention it demands, and according to some more than it demands, if such a thing be possible, for truth will generally tolerate all the magnifying power that can be applied, despite aberrations in the lenses. Pathogenetic symptomatology, cyclopædias, text-books, and repertories are sufficiently abundant to make this step easier than the first, though scarcely yet a mechanical process. And, by the way, if "*similibus*" repertories are an aid why are not "*similia*" symptomatology feasible, or even a combination of the two in one desirable?

The final work of the homœopathic clinician is the selection and application of the *similimum*. This is our conception of the Clinical Medicine of Homœopathy. The clinical work of the homœopathic physician—his practice—however ends only after incorrect methods of hygiene and dietetics are supplanted by definite instructions, and other causes of disease investigated and as far as possible removed; the common sense of good nursing outlined; and finally if necessary, palliatives of suffering applied, each one as he would have others do for him. This supplements the Clinical Medicine of Homœopathy, which is not therefore synonymous with the clinical practice of homœopathic physicians, which is only a part of the whole.

The methods often pursued to advance this Clinical Medicine of Homœopathy seem to be quite out of harmony with the scientific spirit underlying its development: like developing arithmetic by still another illustrative example in addition or the rule of three. As a matter of course cures will follow the methods of the homœopath when empiricism would fail. Dr. Watson, in an article appearing in a late *HAHNEMANNIAN MONTHLY*, resounded the note of warning uttered by Hahnemann and emphasized by Dake in

his late autobiography. It is only "practical empiricism" to grow enthusiastic over the virtues of a remedy in a certain disease or even case. It is quite natural to feel pleasure in congratulating ourselves on our successes compared with the successes of our empirical neighbor. But the times of love-feasting, pat-me-on-the-back-and-I'll-pat-you, have passed with men who claim to be dealing with laws of nature.

THE TREATMENT OF ACCIDENTS OCCURRING DURING THE ANÆSTHETIC STATE.

BY HERBERT L. NORTHROP, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Sept. 14, 1892.)

THE opinion prevails more or less generally that any and all complications arising while administering a general anæsthetic are to be dealt with by means of a few hypodermic syringefuls of brandy. This is the first and favorite method of treatment. The knowledge of many practitioners of the means of resuscitation, as has been shown to me over and over, stops here. A serious accident in the hands of a skilled anæsthetist should be, and is, a rare thing. With a proper appreciation of his responsibility, presence of mind, and *anticipating* a complication, with means, if it comes, to immediately cope with it, an alarming and endangering accident will seldom occur.

I need say but little of the complications occurring during the primary stage of the anæsthesia. If there is any trouble at all at this time it is due to respiratory irritation, manifested by coughing, or a sense of suffocation. These may be present to a slight degree in any and all cases, but, if severe enough to give trouble, the fault lies usually in the too rapid and too free administration of the anæsthetic. If this is the cause, give a less concentrated vapor; do not be in a hurry, and time and after-trouble will be saved. The secret of a rapid, but quiet, easy production of the anæsthetic state is in giving a continuous vapor, and at the same time as concentrated a one as can be borne without exciting undue respiratory irritation.

Struggling during the second stage may be violent and prolonged. Do not use too much force in restraining the patient; simply sufficient to keep the case covered up on the bed or table, and the inhaler in position, accurately fitting the face in order to secure all the vapor possible.

Before complete narcosis is produced, as well as afterward, what we call respiratory spasm may occur. The symptoms of this condition are, cessation of breathing, fixation of the lower jaw and epiglottis, lividity of the countenance, and, if there is a bleeding wound, a dark, venous flow from it. The appearance of the patient alarms one immediately, and the longer the spasm is allowed to persist (I say *allowed* to persist, for I have never known a respiratory spasm to relieve itself), the more alarming the condition becomes. The cause of this spasm is probably irritation by the inhaled vapor of the pharyngeal and laryngeal nerves, resulting, reflexly, in a tonic contraction of the maxillary, pharyngeal and laryngeal muscles. It may occur in any case, but is most frequent in fleshy, thickset, "bull-necked" individuals, particularly men. And, by the way, for these "bad breathers" I believe that chloroform is, as a rule, far the better and safer anæsthetic.

The question now is, how can respiratory spasm be prevented, and, if occurring, how can it be overcome? Now, I must emphasize most earnestly the important rôle played in this complication by the lower jaw, and tell you that the secret of a vast amount of botched anæsthetizing lies in the fact that not enough attention, or none at all, is paid to its position. The lower jaw can cause fatal mischief, and it alone can save the life with which the anæsthetist is entrusted. No experienced anæsthetist will, from the time that unconsciousness supervenes until consciousness returns, be ignorant of its position, or of the effect of its position upon the respiration. It *must* be raised, lifted, elevated, pushed forward, best done by lifting it from behind the angles and held in the correct position, which is one similar to the deformity of a bilateral dislocation of the inferior maxilla. It not infrequently demands the use of much strength, exerted during the entire period of anæsthesia, to control the jaw. One case which I remember required one person to hold the inhaler and administer the ether, and another, using both hands, to keep the jaw extended.

How can a respiratory spasm be overcome? Many experiments have been made upon living and dead subjects, human and animal, to determine the most effectual method of putting the pharyngeal walls upon a stretch, and of lifting the epiglottis from its fixed position. As a result it has been shown that the very position of the jaw that I have described to you as so necessary to safe and easy anæsthesia, is the one to be secured in restoring the respiratory function again, for it is by forcibly extending the jaw that the tongue is

lifted, and if traction is made upon the *base* of the tongue, the epiglottis is freed from the glottis. The greatest amount of extension of the jaw (and, likewise, the greatest traction upon the tongue and epiglottis) is obtained by first flexing the head, *i.e.*, throwing it moderately forward toward the chest, and then, at the same time, forcibly elevating and throwing upward the lower jaw, making simultaneous flexion of the head and extension of the jaw. Sometimes this fails to permit the entrance of air to the lungs. If so, the next thing to be done is to force the index finger between the buccal wall and the jaw, and make it enter the mouth back of the molar teeth. A finger of each hand may be simultaneously thrust into the mouth in this manner on each side, lifting the tongue near its base, and, of course, with it, the epiglottis. This little method is of great value, and, I have every reason to believe, originated in the Hahnemann Hospital of this city.

After a proper trial of one or both of these restorative measures the anæsthetist is usually relieved to see the patient gasp, the cyanotic condition disappear, and the respiratory function automatically continued. Not so, however, in some cases. Then a gag must be insinuated between the teeth, and the tongue grasped with volsellum forceps, traction made upon it, when the lungs will be filled with air. Just as soon as the breathing is again established, the forceps should be removed, the tongue allowed to drop into the mouth and the jaw elevated.

Mucus in the pharynx and larynx may seriously obstruct the breathing. It will be present in many cases despite all efforts to prevent it. It is almost sure to complicate if a large quantity of ether has been given in a short time, particularly at first. It must be removed by lowering the head below the level of the shoulders and turning the face to one side, thus allowing it to flow into the buccal cavity, whence it may be wiped out. If this is not sufficient, it may be removed by repeated swabbings with cotton and curved polypus forceps.

Vomiting during the anæsthetic state is a very serious complication, because of the great liability of the introduction of vomited matter into the lower respiratory passages, obstructing them. It signifies, too, a poor anæsthetist, except where food or drink have been taken shortly before the administration. As soon as the retching begins, quickly force the anæsthetic, pouring it on freely, and keep the jaw well elevated. Do this to produce complete relaxation and prevent vomiting, if possible. If it ensues, lower the head

and shoulders, turn the patient over on the side or face, keep the jaw up, and wipe out all vomited matter from the mouth and pharynx. Renew the inhalations as soon as possible. If the respiration becomes obstructed, invert the patient, draw out the tongue, clear the pharynx and larynx, and, if resuscitation is not quickly secured, perform as low a tracheotomy as possible, followed by artificial respiration after the Sylvester method.

Again, the breathing may become shallow, intermittent or cease entirely, without being obstructed. If simply sluggish, remove the inhaler to supply fresh air, and administer a few drops of spirits of ammonia by inhalation. If this is ineffectual, a most excellent plan is to pour a little ether upon the exposed epigastrium. This causes a shock by the cold produced, and, for me, has never failed to revive the respiratory acts. Ice water may be used in the same way. Aromatic spirits of ammonia, a few drops hypodermically, may be used, and repeated if necessary. The patient may be inverted. If these measures do not stimulate the breathing, before performing artificial respiration, or, together with it, thoroughly stretch the anal sphincters with the thumbs, or, better, with a bivalve speculum. This is advised by Dr. Pratt in all cases where the breathing is faulty. However, I believe that he, with others, resorts to this unpleasant procedure more frequently than is necessary. For instance, if I am not mistaken, Dr. Pratt stretches the sphincters when the breathing suddenly stops, the face becomes cyanotic, and the jaw is fixed—in short, when there is a respiratory spasm. Stretching the sphincters will relieve this *reflexly*, but extending the jaw and raising the epiglottis, as I have described, will do it *directly*. The cleaner, more pleasant and just as effectual method is certainly preferred. As far as my experience goes, it has never been necessary to dilate the anal sphincters to overcome a spasm of the glottis and respiratory muscles. The sphincter stretching must never be forgotten, however, if there is a failure of the respiratory centre, manifested by shallow, intermittent breathing. Lastly, artificial respiration should be performed unceasingly until it is certain that either life is extinct or that the respiratory function can go on of itself without aid.

Failure of the circulation will sometimes need attention. A withdrawal of the inhaler upon the first symptoms of heart failure will, if the administration has been properly conducted and if no hæmorrhage has occurred, sometimes be all that is necessary to improve the pulse. Hypodermic injections of brandy will be in order, of

course, from education and habit, even if without *great* value. Inhalations of spirits of ammonia are frequently of service in bringing back tone and volume to the pulse. Aromatic spirits of ammonia may be injected in small, repeated doses into the circulation. Digitalis, digitalin, strophanthus, or a mixture of digitalis and strophanthus may be used. Probably of greater value in many cases (but not in all) than any stimulant I have yet mentioned is the following mixture: Benzoic acid, 1.5 grms.; camphor, 1 grm.; rectified spirits, 12 grms. This is, undoubtedly, one of the best heart stimulants for collapse under an anæsthetic. There is no special dose; it may be given a hypodermic syringe-ful at a time and repeated frequently. This mixture overcame a serious collapse in a case where I had tried all the agents I have mentioned and nitro-glycerine besides. I believe it saved a life in this instance, for both heart and lungs were about to give up the battle. In other cases not so serious as this one it has answered every purpose. On the other hand, all the first-mentioned adjuvants, including the benzoic acid mixture, failed in another case, and nitro-glycerine, a one per cent. solution, two minims hypodermically, and the same dose repeated later, restored the crippled circulation.

Nitrite of amyl by inhalation is of great value, but more particularly in collapse under cocaine and chloroform. Use it cautiously.

Inversion of the patient, bandaging the upper and lower extremities, flagellation, etc., must always be part of the treatment in serious cases.

The circulation is quickly affected by a hæmorrhage, and is affected immediately if the hæmorrhage takes place suddenly. Collapse from this cause needs the most skilful treatment effectively carried out at once. A fatal condition is brought about when from one-half to three-quarters of the total quantity of blood is suddenly removed. When such an amount is lost, aromatic spirits of ammonia, brandy, mixtures, and all, when used alone, are mere playthings to the toneless, collapsed vessels frantic for fluid, but not necessarily frantic for blood. The composition of the blood is unaltered; it is the quantity which is at fault. This has been suddenly lessened, and the arteries now take little or no part in propelling onward the blood that is left; so the circulation fails, for the heart cannot do it all.

One of the first things to be done is to bandage the upper and lower extremities, to diminish, as it were, the size of the vascular

system, and to more thoroughly fill the important vessels of the trunk and brain. Elevate the lower limbs to an angle of at least forty-five degrees, and surround the patient most thoroughly with blankets and hot-water bottles. Of the different drugs, probably the benzoic acid mixture and glonoine will have the best effect in stimulating the heart.

If the above treatment does not prove effectual, probably there is only one thing that will, and that is transfusion. The anaesthetist has done only half his duty if a patient under these circumstances dies without having had injected into the bloodvessels a sufficient quantity of some fluid not injurious to the blood or to the tissues of the body. A three-fourths per cent. solution of common salt in water, at a temperature of about 100° F., answers all the requirements, and is the solution most frequently used. One method is to open a convenient vein, usually one in the arm, introduce a canula, and to it attach the injecting apparatus. Another method is to thrust a large-sized hypodermic syringe needle into the femoral artery just below Poupart's ligament, and, by gravity, allow the fluid to enter the vessels. The former method is preferable.

One form of apparatus is a simple glass syringe attached to the upright of a "T"-shaped india-rubber tube, one arm of the "T" connecting with the bowl of saline solution, the other with the canula in the vein. An assistant compresses first the arm on the canula side while the syringe is being filled; then the arm on the solution side while the syringe is emptied. It is claimed that there is no danger of injecting air into the vein, but I think it would be difficult to prevent it.

For my part I prefer the gravity apparatus, which is quite simple, and is, with care, unattended by any danger whatever. This consists of a small bowl, connected with the canula by means of india-rubber tubing, and three stop-cocks, one at the bowl end and two at the canula end. By means of these stop-cocks transfusion may be interrupted, and, if necessary, repeated later, the canula being left in position in the vein.

The solution is prepared by adding to each pint of recently boiled or distilled water one drachm of clean table salt. It should be injected at blood-heat, at the rate of a pint in ten minutes. The quantity of fluid to be injected should correspond, as nearly as possible, to the quantity of blood lost, and it also depends upon the effect of the injection upon the pulse. As in a fatal hæmorrhage usually from three to four pints are lost, about this quantity should be employed.

Whether transfusion is practiced or not, as soon as the patient is conscious enough to swallow I think it of great value to administer frequent teaspoonful sips of hot water, every half hour giving a drop of a 1 per cent. solution of glonoine in water. This should be kept up as long as the quality of the pulse is at all questionable, or the thirst, dyspnoea and restlessness, so characteristic of the loss of blood, are present.

In summarizing, I wish to call especial attention to the necessity of keeping the lower jaw raised; to the fact that brandy is of limited value in treating collapse under an anæsthetic; to the value of benzoic acid, camphor and alcohol, and of glonoine; and to the urgent call for transfusion, with other measures, when there has been a severe hæmorrhage.

PROCIDENTIA UTERI AND HYPERTROPHY OF THE CERVIX.

(With two Plates, three Pathological Specimens, and twelve Microscopic Slides.)

BY THEODORE J. GRAMM, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

PROCIDENTIA uteri especially associated with hypertrophy of the cervix has attracted attention for many years, no doubt on account of the obvious abnormality which it produces. It is quite probable that formerly that form associated with laceration of the perinæum and depending on the changed nutrition thereby produced was much more prevalent than now, since the application of plastic surgery to this region of the body has done so much to restore to their normal condition the pelvic floor and the natural supports of the uterus. It is reasonable to presume that if the present views of the ætiology be correct, and if the treatment of laceration and relaxation of the pelvic floor and of the uterine supports continues to advance in professional favor, as has been the case within the past decade, that exquisite cases of hypertrophy of the cervix and procidentia will not often exist, except in places removed from large hospitals and centres of medical education.

It is interesting and curious to read the history of this abnormal condition which so greatly curtails the happiness and impairs the usefulness of women in advanced life. It is recorded that formerly patients were suspended by the feet from a ladder for twenty-four

hours; and under the idea that the uterus possessed independent life the prolapsed parts were subjected to vile odors produced by fumigation from which it was expected to recede; likewise, in order to frighten the prolapsed organ into place again, it was advised that it be attacked with a red-hot iron as if to burn it; for the same purpose it is said that mice and lizards were bound to the womb. That such treatment may at times have been temporarily successful could be explained through reflex contraction of involuntary muscular fibres. In addition to this, treatment formerly consisted in replacing the organ and having the patient lie quietly for a length of time with the knees tied together. Mechanical supports made of wood were also used, as were masses of wool dipped in myrrh; and other astringent substances were applied locally, with, of course, better effect. As, however, modified views of the pathology were entertained, operative procedures were instituted, and later, plastic operations on the pelvic floor and upon the uterine supports were inaugurated. Such to-day is the treatment of this malady.

It is my desire at the present time to place before you the altered anatomical relations which exist in procidentia uteri with hypertrophy; and likewise to point out the histological changes which exist when this condition obtains. For this purpose, however, it will be necessary to refer briefly to the anatomy of the parts when in a normal state. This is all the more necessary in view of the fact that the hypertrophic changes in the several portions of the uterus are not always taken into account when treatment is about to be instituted; but the pendulous masses protruding, to a greater or less extent from the vulva, are sometimes classed promiscuously under the term procidentia, and are regarded as a single condition. The facts, however, are, that the clinical condition known as procidentia uteri may comprise any one of several essentially different conditions which demand different treatment.

The anatomical divisions of the cervix first suggested by Schroeder are correct from a practical point of view, and since the treatment is different, as the several parts are involved or most involved, they should be thoroughly understood, and the anatomical relations of each part constantly kept in mind.

Schroeder divides the cervix into three parts—portio vaginalis, portio media and portio supra vaginalis. The portio vaginalis is that part of the cervix lying below the attachment of the anterior vaginal wall, and, therefore, within the vagina. Anteriorly, but separated from it by the anterior vaginal wall, lies the bladder.

The upper two-fifths of the anterior vaginal wall is in close anatomical relation with the bladder, and furnishes a point for readily entering the bladder by way of the vagina.

The *portio media* is that part lying below the attachment of the posterior vaginal wall to the cervix. Posteriorly is the rectum, intimately connected with the lower two-thirds of the vagina, while behind the upper part of the vaginal cul-de-sac is the retro-uterine fold of peritonæum. Anterior to this median portion of the cervix is the bladder, to which it is attached. Above the attachment of the posterior vaginal wall is the supra-vaginal portion. Anterior to it is the bladder, and just above and sometimes between it and the bladder is a fold of peritonæum reflected downward from the uterus. Posterior to the supra-vaginal portion is a mass of connective tissue, and behind that the peritoneal cavity. It will be seen from even this brief statement of the anatomy that these facts should be thoroughly borne in mind when operative interference is premeditated, in view of the fact that the bladder, the rectum and the peritoneal cavity may be unintentionally opened during operation and the dangers incident thereto be added to an otherwise comparatively safe operation.

Hypertrophy of the infra-vaginal portion is the least common form. It may be congenital, or developing later, is sometimes seen before puberty, the os protruding from the vulva or filling the orifice in the hymen.

If cases such as this be not seen before marriage they usually seek a physician on account of sterility. An examination reveals the mass protruding from the vulva, having its mucous covering transformed so as to resemble the ordinary integument of the body or eroded or ulcerating from external irritation.

If the case be not of such an aggravated form, the os is found occluding the orifice in the hymen or lying just within the introitus vaginae. On inserting the finger the vagina is found to be of normal length, the anterior and posterior cul-de-sac being at the usual distance from the outlet, or the vagina is found to be prolapsed or invaginated because of the weight of the cervix pulling down its attachment. This is also favored by the axis of the uterus being changed to conform to the axis of the pelvis by reason of the hypertrophy. The sound, often difficult to insert into the stenosed os tinctæ, will be found to press much farther than the usual six centimetres, and bimanual examination will show the fundus in its normal position or retroverted and descended into the pelvis.

Sterility is not invariable in such cases. Tait cites Simpson, who had a case in which the cervix measured between four and five inches long, and ultimately required craniotomy to effect delivery; also a case in which an incision two inches deep was necessary to bring about delivery. Another case is also referred to by Tait (A. J. O., November, 1889) in which Cæsarean section was performed, probably under the mistaken idea of an extra-uterine pregnancy. In this connection another case of Tait's is of interest, in which it was necessary to amputate two inches of the cervix in order to reach an intra-uterine polypus.

The treatment of this form of hypertrophy is amputation by means of the écraseur, with subsequent dilatation of the canal of the cervix, which, after this method of operating, usually remains small, contracted and cicatricial. Preferable, however, is the operation suggested by Schroeder, in which the cervix is amputated by the knife, a wedge-shaped piece being excised all around and the edges brought together by suture. This method of treatment, used by Prof. B. F. Betts, in a case operated before the class at the Hahnemann Hospital during the past winter, was followed by most excellent results. After healing had taken place the cervix presented an almost ideal condition, having a regular outline, a smooth surface and the os being of a normal size. The specimens from this case are herewith submitted by permission.

Hypertrophy of the next division of the cervix, the portio media, cannot be disposed of so easily, and is a much more serious condition. In considering this form it would be well to recall its anatomical relations previously referred to, the most important of which is the intimate relation of the bladder anteriorly.

A complex series of events are comprised in the aetiology of this and the next form of hypertrophy of the cervix. Properly to consider them would require that most of the primary and exciting causes of downward displacements of the uterus should be reviewed. But while it is out of the question to do this fully at present, a brief reference to some of them cannot be avoided.

Prolapse of the uterus with hypertrophy of the middle and upper portions of the cervix occurs rarely or never in the unmarried or in those who have not borne children, but finds the most perfect condition for its occurrence in those who have borne several children, especially if their station in life demands severe or continued physical exertion. In such patients, especially as age advances, this malady frequently hampers their well-being.

Anything which increases the weight of the uterus can readily be understood to be an exciting cause for a downward displacement of the uterus; such as tumors either in the uterine cavity, within the walls or beneath the peritonæum; pregnancy with its physiological hypertrophy of the whole uterine tissue; or hyperplasia with its hypertrophy of connective tissue only; and these need not be enlarged upon. Acting in a similar way, but as indirect causes, are violent attacks of coughing, violent muscular exertion, frequent straining at stool as in habitual constipation, constriction of the abdomen from heavy clothing suspended from the waist, as also intra-abdominal tumors and ascites.

The most potent causes, however, and the conditions most frequently found associated with it, are such as bring about an atonic condition of the uterine supports, and such as acting from below upwards either fail to support the uterus or drag it down.

These conditions are most exquisitely produced as a result of pregnancy and especially of its frequent recurrence, when complete recovery has been interfered with, and when a return to their normal conditions has not taken place in the uterus, in the vagina and in the pelvic contents in general, or as a result of any of the accidents incident to childbirth.

Under these circumstances the uterus, including the cervix, remains enlarged and turgid, much softer than normal and increased in weight. The vagina is found in much the same condition, the walls being thickened, the physiological varicose condition of its veins persisting and its dimensions increased, both laterally and measured from above downwards. The uterine ligaments, so recently stretched to that surprising degree necessitated by pregnancy, retain much of their turgescence, are lax, and have not acquired the tonicity requisite to perform their functions. The absorption of fat from the pelvis in general and from the connective tissue surrounding the vagina in particular, is another important factor in supporting the uterus which is lost.

From this brief statement it is seen that in themselves these several conditions, usually included in the term subinvolution, have much to do in bringing about a downward displacement of the uterus, and in producing those conditions primarily associated with proidentia, especially with hypertrophy.

In addition to these, however, there are other factors at work which are the accidents of parturition; namely, lacerations of the cervix and perinæum with relaxed outlet or pelvic floor. These act by

maintaining a congested condition of the involved parts, and permitting the organs in anatomical relation above to sink down in the pelvis or extrude from the vulva.

In the case of lacerated cervix there is, first of all, a congested condition maintained during the period of partial or complete healing by the process of granulation; and after that is complete there is still usually not a restoration of the parts to the normal, and the vessels are not properly supported by reason of the imperfect union. This permits not only a too ready congestion to occur, which is abnormally increased at each menstrual period, but by every other cause tending to augment the blood supply of the uterus. Thereupon it often happens that ectropion or eversion of the lips is added with its erosion of the cervix.

When the perinæum is lacerated, while by no means the only support of the uterus nor one acting to a very material extent in a direct way upon the uterus is removed, yet the supports of the vagina and to some extent of the uterus also are materially diminished, and as a consequence there is retroversion with desensus uteri and prolapse of the vagina or so-called cystocele and retrocele. When these conditions occur in part or in combination, there exist most of the prerequisites of hypertrophy of the cervix.

It is well known that opinions differ as to the course of events in the production of hypertrophy of the cervix, it being contended by some that hypertrophy of the cervix is the primary event, and by others that prolapse and its attendant conditions originate the vicious circle.

Without reviewing the several theories advanced, it must suffice for the present to say that the weight of opinion to-day favors the view that the hypertrophy follows the displacement and its attendant changes of circulation. That such, however, may not always be the fact is suggested by a case, interesting in this connection, reported by Dr. Carl Beck in the *American Journal of Obstetrics*, vol. xxvi, page 24. The patient, aged 38, single, presented well-marked hypertrophy eight months after confinement, at which, though the perinæum was lacerated, it was repaired at once. In reading the case the question truly arises, how much influence was exerted by the cystitis from which the patient suffered six weeks after confinement, and also by the fact that three months after confinement she resumed her occupation of cook. A diagram of the internal anatomical relations and a representation of a microscopic section of hypertrophied tissue add interest to the case.

In the production of these two forms of hypertrophy of the cervix, that is, of the middle and upper portions, the train of events is usually as follows: After a confinement at which the perinæum was lacerated, subinvolution of the uterus and vagina remain. A laceration of the perinæum may have occurred, or, what is far worse, an overstretching or laceration of the fibres or attachments of the muscles forming the pelvic floor. As a result the pelvic contents sink down and the redundant vaginal tissue presents at the vulva and soon after prolapses through the outlet. As a consequence of this prolapse the cervix is dragged upon and follows the line of traction. The natural return of blood being impeded, the displaced parts remain congested and tumid, and in a condition to be lengthened by the downward traction, especially if the uterus be fixed in the pelvis by perimetrial adhesions. Even without adhesions the uterine ligaments do not allow an indefinite drawing down of the uterus, but after allowing it to go a certain distance hold it more or less securely, while below the elongation the congestion and the inflammatory and hypertrophic changes are going on.

In cases where this state of affairs exists the portio vaginalis is least affected, but the untoward influences are most exerted upon the portio media and the portio supra vaginalis.

In a typical case of procidentia uteri with hypertrophy of the portio media, the changed anatomical relations of the parts merit attention. On viewing the protruding parts it is not possible at once to determine its pathological character or its relations. There may be only an aggravated prolapse of the vagina, while the uterus is well within the pelvis. Such is the case in a patient at present coming to the Hahnemann Hospital Dispensary. In her the protruding mass closely simulates the protruding mass in cases of hypertrophy, while her uterus is but slightly descended and is undergoing senile atrophy. It is only after digital examination and measurement that these cases can be diagnosed.

In median hypertrophy the os is found at the lower part of the mass. On attempting to insert the finger into the anterior cul-de-sac, it is found to be impossible since there is none. The anterior vaginal wall is stretched over the anterior aspect of the tumor and the cervix in its descent has drawn with it a portion of the bladder which forms a diverticulum on the anterior face of the cervix. Posteriorly the vaginal vault has not been much affected, and is about at its normal height, because the hypertrophied part is attached below the insertion of the vagina here. The distance from the pos-

terior fornix to the os is much increased, and is approximately a measure of the amount of hypertrophy present. The rectum is unaffected, lies in about its normal position, and is of normal shape. On bimanual examination the fundus will be found nearly in its usual position as regards its height in the pelvis, will be either erect, anteverted or retroverted, and with a finger in the posterior cul-de-sac or within the rectum, the fundus, the supra-vaginal portion, the hypertrophied median portion and the portio vaginalis may be successively palpated. The sound passes a considerable part of its length into the uterus, perhaps about 15 centimetres.

The uterus may be more or less completely replaced, when the fundus will rise a corresponding distance into the abdomen, or, if anywhere attached, will be turned to either side, forwards or backwards, toward its point of attachment.

While the parts are prolapsed a sound or male catheter introduced into the bladder will demonstrate its shape above or behind the symphysis, and likewise will show the diverticulum downwards, resting on the anterior aspect of the protruding mass.

A careful examination made in this manner will demonstrate the fallacious views of those who hold that hypertrophy rarely occurs, and when apparently present is due only to a stretched condition of the cervix which disappears when the patient is placed in the knee-chest position.

The fact that reposition and retention reduce the size of the prolapsed parts, demonstrates how much influence is exerted by impeded circulation, since they relieve this condition and diminish the total mass by just that much. The accompanying photograph, No. 1, shows the external appearance of a case which has been treated entirely by this method for several months at the Hahnemann Hospital Dispensary. When the patient first applied for treatment a large pendulous mass protruded from the vulva, made up of hypertrophied tissue in a highly congested state. The latter condition has been much relieved by persistent treatment, applied about every three days, which consisted in causing the woman to refrain from laborious work, replacing the prolapsed parts within the pelvis and inserting a boro-glycerine tampon. At first the tampon would remain but an hour or two, but gradually the time increased, and the tampon would remain two days. The improvement which has taken place consists in a diminution in the amount of blood in and about the cervix and vagina. The length of the hypertrophied part is much the same; the enlarged fibrous cervix is still present.

This patient will not be well before excision of the hypertrophied part and repair of the greatly relaxed pelvic floor and outlet.

In hypertrophy of the supra-vaginal portion, the pathological anatomy is different still. Here while the length of the vaginal walls, both anterior and posterior, is increased, the relative proportion of each to the other is maintained. Indeed, the anterior may

PLATE I.



Median hypertrophy of cervix, after treatment for several months by tampons, etc. Patient is about to be operated.

be larger than the posterior, and this will be so when the median portion is also hypertrophied, as is often the case. The tension then is greatest on the anterior wall, while the posterior, coming down with the prolapsed part, may lie in folds outside the body. Above the vaginal attachments is the elongated and hypertrophied part.

The anatomy of the anterior aspect of the prolapse is much the same as in the previous case, the cul-de-sac being obliterated, and a portion of the bladder lying outside of the body. Posteriorly the

cul-de-sac is gone or much less deep, for much of the vagina here is prolapsed. A portion of the rectum is drawn downward, and is outside of the body, forming a true rectocele. The hypertrophy is above the vaginal and median portions, displacing these downward, and likewise displacing the fundus upward, as a recto-abdominal examination will demonstrate. Examination by the sound in the uterus and in the bladder shows the same result as in the previous case.

PLATE II.



Supra-vaginal hypertrophy of cervix.

Photograph No. 2 shows the external appearance of such a case. The patient is thirty-three years old, is married, and has had five children; the pelvic floor is much relaxed and offers little or no support, and the perinæum is lacerated. The greatest diameter of the prolapsed part is 6 centimetres. The anterior cul-de-sac is obliterated, the anterior vaginal wall being entirely outside of the body. From the meatus urinarius to the os uteri is 6 centimetres. The posterior vaginal wall is almost entirely outside the body, the finger

only entering the vagina $2\frac{1}{2}$ centimetres. There is a true rectocele, as demonstrated by the finger in the rectum and also shown in the photograph. The fundus is retroverted, and the sound passes 12 centimetres. The bladder reaches to within $1\frac{1}{2}$ centimetre of the os anteriorly. The treatment of these abnormal conditions is demonstrated in the report of the following cases.

CASE II.—Patient of Dr. W. H. Barnes, aged 37 years, married seventeen years, has had two children, sixteen and eleven years old.

At the birth of the first child she says the doctor in attendance had much difficulty to keep the womb up in place during each pain. This statement, made voluntarily by the patient, may justify the assumption that there was already then some hypertrophy of the cervix, which on that account was slow in dilating. During this labor the cervix and perinæum were lacerated. It was five years after this birth until the patient became pregnant again. Four or five years after this she was operated for lacerated cervix and perinæum, and at the operation it is said that a portion of the cervix was amputated. Since this operation she has gradually developed "falling of the womb," so that when seen by myself she had a large mass protruding from the vulva. Her menstruation takes place every three weeks, is profuse, and lasts eight days. She has a yellow leucorrhœa, which is sometimes bloody.

Physical Examination.—Protruding from the vulva and hanging down about 10 centimetres is a pyriform mass, covered by mucous membrane, which is 6 centimetres across its widest width. At the lower segment the os uteri is seen, and on the left side there is some scar tissue from the previous operation. The mass is soft, and may be lifted up, showing the posterior commissure of the vulva. On attempting to pass the finger into the anterior vaginal cul-de-sac, it cannot enter, but meets the mucous membrane and vaginal wall reflected from the symphysis pubis. The same occurs laterally. The posterior cul-de-sac may be entered by the finger. The sound may be made to enter the os uteri for a distance of $12\frac{1}{2}$ centimetres, after passing through a tortuous cervical canal.

Bimanual Examination.—With a finger underneath the tumor and in the posterior cul-de-sac, the fundus may be felt about in its normal position, i.e., about an inch or more above the symphysis pubis.

Per Rectum.—The previous record is confirmed. Laterally the examination is negative.

Per Urethrum.—A male catheter may be made to enter the in-

flamed urethra, and after passing somewhat upward under the symphysis pubis it turns and goes downward into the lower portion of the tumor.

The measurements are as follows :

From the posterior commissure of the vulva to the posterior vaginal fornix, 5 centimetres ; from the fornix to the os uteri, 8 centimetres. Total length of the posterior vaginal wall from the posterior commissure of the vulva to the fornix and down on the posterior lip of the cervix is, therefore, 13 centimetres.

There is no anterior fornix, but from the urethral orifice downward to the os uteri the length is 6 centimetres. This distance represents the length of the anterior vaginal wall.

Operation.—Supra-vaginal excision of the cervix. Patient in dorsal decubitus. After removing the pubic hair, thoroughly cleansed the parts externally and the vagina, and disinfected with bichloride solution.

A strong silk ligature was then passed through the cervix at its lower extremity and tied, to be used as a tractor. An incision was then made around the under surface of the mass about $5\frac{1}{2}$ centimetres above the os uteri. The incision was carried diagonally downward and forward on each side to meet in the middle line on the anterior surface about $1\frac{1}{2}$ centimetres above the os. The vaginal tissue covering the cervix was then dissected upward as is done in vaginal hysterectomy, until the point was reached where amputation was contemplated. The cervix was then split up laterally to the same point, and the anterior lip removed by a wedge-shaped incision. The loosened and puckered vaginal tissue remaining, and which had been pushed upward and out of the way, was then caught and united to the anterior lip of the cervix by suture. The posterior lip was then treated in the same way. The posterior lip was not at all vascular, but quite bloodless, hard, fibrous and thickened.

In cutting upward to make the wedge-shaped incision to remove the posterior lip of the cervix, the peritoneal cavity was opened about 7 millimetres in diameter. This was immediately closed with fine buried catgut suture.

The posterior vaginal tissue was then likewise united to the cervix, and a few catgut sutures were used to unite the mucous membrane in the lateral fornices. The uterus was replaced and held up by iodoform gauze. Strict antiseptic precautions were maintained throughout the operation.

The after-treatment and ultimate recovery was entirely without

incident, with no rise of temperature above the normal, the patient in the next two weeks wondering all the while why she must lie in bed after she was "all right."

It was my intention to do Schultz's operation should there be any prolapse of the anterior vaginal wall after the patient was up for some little while; and also a colpo-perineorrhaphy. The patient has, however, persistently refused to have anything further done, since she cannot be convinced of the necessity for these plastic operations, since the former operation has relieved her of what to her mind was her trouble. The question therefore arises whether in a few years a return of the trouble may not be expected.

CASE III.—Applied at the Hahnemann Hospital Dispensary September 2, 1891. Is a woman aged 46 years, Irish by birth. Has had ten children, oldest twenty-eight, and youngest eight years old. About sixteen years ago had two miscarriages. Her menstruation when not pregnant or nursing has been regular. At present she menstruates every three weeks; the flow is profuse, lasting one week and attended by very little pain.

She came to the Dispensary complaining of little else than back-ache and that "the womb comes out," which she attributed to having been kicked by her husband. That such was the case alone seems doubtful, for being a woman of dissipated habits and compelled to do laborious work, in addition to her frequent pregnancies and the lacerations of the uterus and pelvic floor, make it extremely probably that other, and in fact, the usual factors brought about her present condition.

On examination quite a large mass was found protruding from the vulva, of which the measurements were as follows:

Length from the clitoris to os uteri, 11 centimetres.

Circumference of the protruding mass, $24\frac{1}{2}$ centimetres.

The anterior cul-de-sac was obliterated.

From perinæum to posterior cul de-sac, 9 centimetres.

Total, $20\frac{1}{2}$ centimetres.

From posterior cul-de-sac to os uteri along posterior lip of cervix, $11\frac{1}{2}$ centimetres.

There was a deep erosion around the os about $2\frac{1}{2}$ centimetres in diameter.

The protruding mass could be replaced but partially, and fell out again as soon as the patient sat up or stood upon her feet.

The patient was admitted to the Hahnemann Hospital and treated preparatory to operation until November 3, 1891, when by the kind-

ness of Prof. B. F. Betts I was permitted to operate her before the class.

At the time of operation it was found that from rest in bed and good hospital treatment the mass had diminished somewhat in size, as is usual in such cases, and its congested condition was much relieved.

The operation was conducted in a similar manner to the one described above, and was followed by good results.

Subsequently, through the kindness of Professor Betts I was permitted to complete case, doing an anterior colporrhaphy according to Schultz's method, in addition to a colpo-perineorrhaphy.

The Specimens.—The macroscopic appearances of the specimens from these cases do not require special description. They have, however, been examined microscopically, sections having been made in different directions in each case. The microscopic slides are herewith submitted. A brief statement of the changes observed in them is as follows :

CASE II.—On the vaginal side there is the usual layer of stratified epithelium, beneath which is the layer of less compressed epithelium filling out the spaces between the papillæ of the mucosa. These layers of epithelium are much thicker than in the normal cervix.

The papillæ of the mucosa are less regularly distributed, the intervals between them being far more irregular than normal. In some places they are of normal length, but in most places they are elongated three or four times and are correspondingly thin, thereby allowing the epithelium interposed between any two of them to dip a great distance into the tissue. In one place four much elongated papillæ may be seen covering one field, and between them layers of epithelial cells. The epithelium on the side of the cervical canal has mostly disappeared as a result of inflammatory action. The capillaries forming the papillæ are much enlarged, as also the vessels at their bases. In this region also are often found masses of inflammatory cells.

The capillaries and bloodvessels throughout the tissue in general are much enlarged and are thick and well developed.

The histological elements of the hypertrophied part are increased both in number and size, with a large amount of fibrous tissue having few nuclei, which in certain places predominates over other elements. In a number of places may be seen enlarged dilated glands forming cysts containing retained fluids composed of remains of de-

generated epithelium, the epithelial lining of the cyst wall having mostly disappeared, but in some places still show columnar epithelium in single rows or layers.

CASE III.—In this case there is far more abundant evidence of inflammatory changes, there being much small celled infiltration beneath the mucosa. In addition many more enlarged glands are seen which dip deeply into the tissue forming deep fissures in some places and cysts in others. With these exceptions what has been said of the previous case holds good in the present one also.

In Case I. sections have been made in a vertical direction directly through the entire amputated portions, allowing the entire cervix to be studied under the microscope. The pathological changes observed are of an inflammatory nature within the tissue, and on its surface the changes incident to catarrhal inflammation.

THE DEPENDENCE OF HOMŒOPATHY UPON ITS MATERIA MEDICA.

BY JOSEPH C. GUERNSEY, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

THE foundation upon which homœopathy was established; the rock upon which it was built; its very dependence, both now and for the future, is the homœopathic materia medica. Hygiene and dietetics, pathology and physiology, besides other collateral branches, are as necessary to its existence as a system of medical practice, as are beams, bricks and mortar to an edifice; but of that edifice, the materia medica is the corner-stone. Or if, instead of an edifice, we regard homœopathy as the arch of cure spanning all the diseases flesh is heir to, then the materia medica is its keystone.

But in spite of this, the tendency at the present day seems to be to make homœopathy depend upon everything else *except* the materia medica.

It therefore will be well for us to look at this matter and try to realize what it means.

Homœopathy—by this we mean the curing of disease according to the law of similars, that like cures like. By this we also mean that life-work which each of us has chosen as the best means of aiding and curing the sick. This curing of disease we can effect; this

life-work we can carry on, only by the proper use of our materia medica.

I may be asked, "Why do you lay so much stress upon the materia medica? How about the *Organon*?"

"The *Organon*," I reply, "when rightly and thoroughly understood, directs the proper application of the materia medica." The early triumphs of homœopathy were owing, not to talking about and explaining the *Organon*, but to the successful application of the materia medica, to the mitigation of suffering thereby, and to the brilliant cures wrought.

Hahnemann and his immediate successors established homœopathy, and they gave it the reputation and proud distinction which it enjoys to-day, through the wonder and admiration they excited at the cures accomplished with the homœopathic materia medica. Moreover, I assert that homœopathy could never have been generated, born and brought into existence without its materia medica; and I further declare that homœopathy has not made any progress whatever since the day of its birth, nor can it ever make any progress in all time to come, excepting by and through its materia medica. There are many collateral branches, which, when taken as a whole, may be termed the science of medicine, *i.e.*, of medicine in general. But the science of homœopathic medicine, *per se*, stands alone.

Homœopathy has a materia medica of its own, and a method of prescribing peculiarly its own.

1. We prescribe according to the law of similars;
2. We give the least possible dose (or quantity) that will cure;
3. We require that all repetition of the dose shall cease while improvement continues.

This is the way true homœopathy was established; this gave it the great name and vast power it enjoys to-day.

Now, from the practice of medicine in general, drop out our provings, our clinical observations and confirmations, our method of administering drugs—for the homœopathic materia medica predicates and requires all these—and where would be homœopathy? It would be like the play of Hamlet with Hamlet left out; it would cease to exist. Observe, that I do not bring up any question of potency; I only ask for the smallest possible dose that will cure, and that it be prescribed as nearly as possible in accordance with the totality of the symptoms. Nor do I attack or defend the question whether, if homœopathy should cease to be practiced, there is or is not, or whether there will or will not arise, a simpler or more successful

method of cure. I only desire that we shall ever bear in mind *the dependence of homœopathy for its very existence upon its materia medica.*

It seems to me that at the present day our materia medica receives much less attention from us than any other branch. On the contrary, all sorts of make-shifts and palliatives are employed. I greatly fear that many of our number are as ready to tamper with phenacetine, anti-febrine, sulphonal, and the numberless other passing illusions which are hailed as wonderful "new discoveries," as are our opponents Koch, who discovered (?) the tuberculosis cure; as Brown-Sequard with his elixir of life; or as Bergeon with his positive cure of consumption by rectal inflation with sulphuretted hydrogen. But while our school is chasing such phantoms, homœopathy is standing still. The provings of the grand old polychrests remain, and are still used, and almost exclusively depended upon. Let us have a change! Let us determine to boom homœopathy in the right way, that we may keep her abreast with the progress of this justly styled progressive era! To do this, let every physician professing to practice homœopathy determine within himself never to administer a drug empirically; never to prescribe with a view to palliate only; let him never administer a remedy unless it be in full accord with the presenting symptoms—like cures like. Away with the giving of anti-febrine to reduce the temperature; with acetanilide to destroy pain! This is only a waste of time; is only treating an effect without seeking to remove the cause of that effect. Also, we must have new remedies, carefully and accurately proved, and then administered, not empirically, as is too much the present tendency, but homœopathically. We also need still more confirmations of the old remedies, with careful weeding out of their possibly still-remaining errors, coupled at all times with earnest and continuous study of the remedies we now have.

In conclusion, we must not forget that we are homœopathic physicians by virtue of our graduation and diplomas. For the sake of consistency, and in honor bound, we ought to feel ourselves committed to uphold and preserve our system of medicine in all its purity, and to develop it to its fullest strength.

MYXŒDEMA FROM PRESSURE ON THE THYROID.—Köhler reports a case in which a syphilitic glandular enlargement in the front of the neck so interfered with the functions of the thyroid as to produce a well-marked picture of myxœdema. Incision and anti-syphilitic treatment resulted in a complete cure.—*Berliner Klinische Wochenschrift.*

THE FARADIC CURRENT IN GYNÆCOLOGICAL PRACTICE.

BY L. WILLARD READING, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

IN the last few years, the greater part of the investigations and writings have been upon the capabilities and possibilities of the galvanic current, while the old time current, the faradic, has been sadly neglected. The conclusions in reference to the special uses of the faradic, still remain in a very unsettled condition. This is due in a great measure, to the want of a guide or standard in the manufacture of faradic batteries. Each maker in the past, has produced a battery according to his own idea and fancy, his particular object being to produce a battery with loud vibrations and powerful current; and hence we have as many different results from treatment, as we have variety of instruments. Since this subject is being so earnestly investigated by the profession, there is a demand for a standard battery. With this object in view, at the last meeting of the American Electro-Therapeutic Association, a committee was appointed to devise some form of battery that would be suitable for the treatment of all forms of disease to which it is applicable. To Apostoli is due the credit of not only giving to the galvanic current its scientific importance and its wide application in special forms of disease; but he has also by much labor and experiment, developed the properties and uses of the faradic. He found the more the wire of the secondary coil was attenuated, the more sedative the properties of the current generated.

Dr. A. H. Goelet has labored earnestly to prove that there is a decided difference in a short coarse wire and a long fine wire secondary coil. Any one who will, can convince himself, by holding in the hand a bipolar electrode, so that both metallic surfaces will be included, and try the effect of the different coils. By increasing the current with each to a point of endurance, a decided difference will be noted, both in character and time. The finest coil will be endured for a much longer time than the intermediate or coarse coil, and at a certain time, will be less perceptible, showing the sedative character of the current. Or by applying the current with a bipolar electrode in a healthy vagina, where the resistance is much less than that offered by the skin, the current from the short coarse wire will

be painful and unbearable, while the current from the long fine wire will not only be bearable, but rapidly sedative.

Engelman's coils are perhaps as satisfactory as any we have been able to procure in the past, although Fleming and the Chloride of Silver Dry Cell Battery Company, of Baltimore are both manufacturing batteries with different size coils, that are very satisfactory. The Engelman coils are three in number: No. 1, number sixteen wire, seventy-five yards long; No. 2, number twenty-two wire, two hundred and twenty-five yards long; No. 3, number thirty-two wire, six hundred and sixty yards long. Brown and Sharp American scale. Dr. Goelet has suggested as an improvement over the Engelman coils, a number sixteen wire one hundred yards, number twenty-two wire two hundred and fifty yards, number thirty-two wire eight hundred yards, tapped at five hundred yards, would give a coil that length and one at three hundred yards, then another or the finest, number thirty-six wire, fifteen hundred yards, tapped at one thousand yards giving additional coils of one thousand and five hundred yards, which would certainly be a perfect battery for a gynecologist. A coil composed of fine wire of great length has an increased electro-motor force and is more able to overcome external resistance, even with the decrease of volume by the resistance of the coil. The current from the two coils, short coarse and long fine wire, are possessed of different physical qualities and therefore produce different physiological effects. The short coarse wire is a current of volume, while the long fine wire is a current of intensity. Or in other words, the first has more amperage and less voltage, while the latter has more voltage and less amperage. While the short coarse wire has greater current strength, it has less power to overcome resistance, because endowed with less electro-motor force. There is not only a difference in the effects produced by the size of the wire, but also in the length of the fine wire of the same size. The electro-motor force of the fine wire secondary coil, is increased in proportion to the number of convolutions that are exposed to inductive influence of the primary coil. Nor is the result the same, if we use the whole length of wire and only half of it is exposed to the inductive influence of the primary current. Therefore I think to get the best results from any particular secondary coil, is to have the secondary coil cover the primary completely, and when applied, place a rheostat or Massey current controller in the circuit. Then you can commence treatment by an imperceptible current, and gradually increase it by lessening the resistance in the rheostat.

Another very important point to consider is the vibrator. It requires care and time to secure a proper adjustment so that we will have no jerks. A perfect vibrator is rare. The one made by Supplee of Chicago, comes about as near to what it should be, as anything I have yet seen, although Fleming of Philadelphia, makes an excellent battery, if one is careful to select the proper length and size of the coils. Every battery should be able to furnish both coarse and fine interruptions. By coarse interruptions is meant from fifty to seventy-five per second, and by fine interruptions from one hundred and fifty to two hundred per second. It would be well also to have it capable of producing slow interruptions, two to five per second. The action of the current depends much upon the interruptions being proportioned to the coil and the effect intended.

There are several points which I wish to particularly emphasize, and the importance of which, will be appreciated by those who desire to use it in the future. One is, that the current intensity should be increased and decreased very gradually, otherwise, it may have a very irritating effect upon the diseased structure, as well as unpleasant to the patient. Another is, that in using the secondary coil of fine wire for its sedative effect, the interruptions should be of the maximum rapidity and be smooth without jerk or shock. But in using the short coarse wire secondary coil for stimulation of muscles, the interruptions must be slow. The reason for this is, that one is to produce stimulation and the other sedation. To produce sedation, our aim is to paralyze the nerves, wear out and cause relaxation of muscles, thereby relieving the painful contractions. Apostoli believes, that faradization relieves by setting up vibrations in the nerve, traveling in the opposite direction to the ordinary or painful impulses. Morton says, the effect is obtained by simple agitation of the mass of the constituent elements of the nerve fibre, and thus an annulment of its capacity to conduct pain impulses, is brought about. Just as concussion or anæsthesia of brain tissue, may be said to annul its capacity to respond to sensory impulses. When the interruptions are rapid, the muscles are not able to respond to every vibration, and remain in a state of contraction until they become exhausted, then become relaxed. So with the sensory nerves, if the stimulation of the current is kept up long enough, they lose their power to respond, and the current produces a condition of anæsthesia which is kept up according to the duration and frequency of the applications. With the short coarse wire we wish to produce stimulation; hence the vibrations must be slow so as to allow of a distinct

relaxation and contraction, thus imitating nature and allowing the molecular changes to take place. There is another effect we get from the long fine wire coil, and that is the stimulating of the vaso-motor nerves and the capillary circulation. The current produces contraction of the bloodvessels and increase of the vermicular movements, which increases the circulation. This hastens the absorption of effete products and combats blood stasis, thereby relieving congestion. To make this still plainer, you must be familiar with the difference of the action of the current upon voluntary and involuntary muscles. In the voluntary, the contraction is as a whole; in the involuntary, it is divided, being a distinct contraction and the vermicular movements. Or, in other words, the whole muscle is not acted on at once, but each fibre in turn, producing thus the normal movement of the vessels. The spasmodic contraction cuts off the supply and the vermicular movements hasten the circulation, thus producing rapid emptying of the bloodvessels. Therefore you can readily understand why it is so useful in lessening capillary congestion. The general opinion prevails that there is no direction to the flow of the faradic current, and that it is not endowed with polarity. Be this as it may, there is a decided difference in an ascending and descending current upon the vermicular movements. A descending current produces an increase of the vermicular movements, and hence an increase of the blood supply to the part, while an ascending current produces a decreased supply of blood by lessening the vermicular movements. Although a milliampere meter, placed alone in the circuit, and with each make and break of the current the needle will oscillate in an opposite direction to about the same degree, yet by careful measurement by Dr. Gordon it has been ascertained that the make current is thirteen times weaker than the break current. Since the make current is so weak, being not endowed with sufficient electro-motor force to overcome the resistance of the human body, hence only one current, the break current, is perceptible. This flows in one direction and is endowed with polarity. That there is a marked difference in the physiological properties of the two poles, can be demonstrated by applying the negative pole to the motor point of a muscle, and moving the secondary over the primary sufficient to produce a contraction; then, without taking off the current, reverse the poles by the pole changer and the contraction will cease. The difference of the effect upon the sensory nerves may be noted by applying the negative pole and the positive pole upon an abraded surface with a fine vibrator. The negative will be

very irritating while the positive will be soothing. Therefore we find there is a distinct mechanical difference in the poles of the induced interrupted current, the negative being stimulating and the positive soothing.

From the preceding pages you can readily infer of what use it would be in gynæcological practice. Whenever we wish to produce sedation or muscular stimulation, we would think of the faradic current. It being an interrupted current, it produces a sort of interstitial massage, heightening the circulation, accelerating the absorption processes and influencing favorably the nutrition of the parts.

I have been particularly pleased with the use of the faradic coarse coil or coil of quantity, in its effects upon the smooth muscular fibres of the uterus, that overcome the primary inertia of the organ and in preventing an arrest of retrograde metamorphosis, thus overcoming such evils as chronic subinvolution with fungous endometritis, salpingitis and their attending complication.

In subinvolution following abortion, when slight hæmorrhage continues for days and even weeks, when all our remedies fail us; in cases of too frequent childbirth and all conditions of debility following parturition when the womb lacks its proper contractile power; in relaxed conditions of the vagina and perinæum with a sagging and dropping down of the whole pelvic contents, and in constipation from settling down of the bowel, there is nothing that can relieve so quickly and accomplish such satisfactory results as the use of the faradic current from the intermediate or coarse wire secondary coil. General faradization or faradization of the spine with positive to nape of neck and negative pole to sacrum, will be found useful for those cases of amenorrhœa due to mental depression or temporary arrest due to cold, when there are no organic lesions. When there are organic lesions, it is useful in conjunction with galvanism, with the negative pole in the uterus and the positive pole on the nape of neck or over the solar plexus. The bipolar intrauterine electrode may also be employed, using the long fine wire coil at first, then the intermediate, then the coarse wire if not successful. In simply diminished flow, especially in persons inclined to take on adipose tissue, applications made by the bipolar vaginal electrode will be found useful, and, even in a great many cases, preventing sterility. The applications should be made every other day, and from five to ten minutes. When there is scanty flow due to uterine catarrh, the bipolar intrauterine should be used to produce local

stimulation. In dysmenorrhœa we find it very useful even in the obstructive type produced by some diseased condition of the endometrium, and particularly when the flow is scanty. You will also find it gives relief from the pain produced by the application of galvanism, using it immediately afterwards with the bipolar vaginal electrode. In the neuralgic form of dysmenorrhœa, nothing will afford so much relief. It must be used every day and persistently during the intermediate period. For the ovaritis that is a result of the dysmenorrhœa of the obstructive type and the pelvic congestion, we must rely upon bipolar faradization of the vagina, using the long fine wire until the improvement ceases, then the shorter wire for stimulation; an application every day until a decided improvement, then every second day.

In uterine displacements of recent origin from accident, etc., we will find the tonic effect of bipolar faradization very useful in strengthening the uterine supports. But be careful to use the long fine wire until all inflammatory conditions subside, and then the short coarse wire will be found more beneficial. In all malpositions due to relaxation after previous existing metritis or endometritis has been cured by galvanism, will be greatly benefited by bipolar faradization of the vagina. If the case does not improve under this form of treatment then use the current intrauterine. In flexions the intrauterine will be more effective. It acts more directly on the muscular structure. Be careful to introduce electrode well up into uterus.

In fixed retro-displacements, if bipolar faradization of vagina will not relieve the sensitiveness enough to commence active treatment with the negative pole of the galvanic current for the purpose of absorption, then it would be well to use the combined current.

Galvano-Faradic.—Some workers, I think, have claimed too much for the use of the faradic current in displacements, with the exclusion entirely of the galvanic. This may do very well for simple displacement, but when we have displacement associated with pathological changes, we must use them together. In superinvolution or atrophy of the uterus, the treatment should be with the negative pole intrauterine and positive over the abdomen or spine, using the intermediate coil. If this is not effective then the bipolar intrauterine electrode should be used. In all cases of salpingitis, where there is evidence of active pelvic congestion, extreme sensitiveness to digital examination and constant harassing pain, it is better to begin treatment with bipolar faradization to the vagina every day,

until perfect sedation is established, using the long fine wire coil with rapid vibrations. It is surprising how comfortable you can make a patient feel under this treatment alone, so much so, that it is difficult to persuade her to continue treatment, as they think they are cured. In pelvic exudates, even in the inflammatory stage, we employ the vaginal bipolar faradization, with a marked improvement in the disease and comfort of the patient. And especially is it useful in those hypersensitive conditions, where the least touch gives excruciating pain. In prolapsed ovaries when tender and inflamed, I know of nothing that will give the patient so much relief, as bipolar faradization in the vagina, using the long fine wire secondary coil with very rapid vibrations. The treatment to last about twenty minutes and given daily.

There are some neuroses, as vaginismus and some irritable conditions of the nervous mechanism of the bowels, when they have that roaring croaking noises which makes her life so uncomfortable and unpleasant, which are entirely removed by the employment of the different coils of the faradic battery. In hysteria the pains and pressure symptoms are removed quickly. The faradic current has been employed with decided success in ectopic gestation, although I believe from my experience with the two currents, that the galvanic is the more effective. It has more volume, is more destructive and is capable of producing chemical changes to the extent of disintegration. The time for using the faradic current is before the third month and with the short coarse wire secondary coil or primary current, as strong as patient can endure, for about ten minutes every day until you have given seven to ten treatments. Its use in fibroids, is limited to the relief of pain and hastening the expulsion of submucous fibroids and polypi from the uterus. The short coarse wire should be used and when possible, the electrode should be introduced into the uterus. I have succeeded in producing quite a number of expulsions of large polypi by this treatment, so that they were easily operated upon and removed. Dr. Baraduc has devised an electrical treatment of uterine fibroids, which consists in a joint use of faradic and galvanic currents. He applies both poles of the combined current on the abdominal walls including the tumor, or one pole against the cervix and the other over the abdomen. He uses the coarse coil and a galvanic current of about one hundred and fifty to two hundred milliamperés. He speaks well of this treatment in those tumors which cannot be treated by the usual or Apostoli's method.

Dr. Massey reports a case of a large soft myoma, which was contracted by the use of the faradic current.

I have refrained from reciting any cases in particular, which I have treated, as it would lengthen my paper unnecessarily, for my particular object in presenting this subject, has been to thoroughly explain the necessity and uses of the different size coils and with a recognition of this fact, what satisfactory results could be obtained. For unless these points are recognized and the current properly applied, success must not be expected, or if obtained, it must be accidental, as far as the operator is concerned. Be very particular to have your diagnosis correct, for if that is correct, your success will be sure.

ACUTE CORYZA.

BY R. E. HINMAN, M.D., ATLANTA, GA.

THOUGH usually classed among the more or less trivial and transient ailments, yet acute coryza often attains the dignity of a complaint, for the relief of which the physician is consulted. From the fact that the complaint is, in the majority of cases, a transient one, the relief expected and demanded is immediate relief. A plan of treatment that has proven very satisfactory to me in these cases, is the following :

First, spray the nostrils slightly with a 2 per cent. solution of cocaine, which relieves the congestion, removing the sensation of "stiffness" and obstruction. In a few moments the patient will tell you that he can breathe freely through the nose. Now cleanse the mucous membrane with a *warm* spray of Dobell's or Seiler's solution. When this is done use a spray composed of liquid albolene, one ounce, gum camphor ten grains, and menthol crystals five grains. Rub the menthol and camphor together until they form an oil, then add them to the albolene.

The stimulating properties of the camphor and menthol lend a sense of positive exhilaration to the patient, and give immediate relief from the more annoying symptoms. This local treatment should be followed by drop doses of *euphrasia* θ or *pulsatilla* θ every hour, as the case demands. Of course aconite will be given should there be any fever. A hot bath with vigorous use of the flesh brush is a valuable adjuvant, especially if followed by a free sweat between blankets.

A CLINICAL STUDY OF *HELONIAS DIOICA*.

BY SILAS GRIFFITH, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

THIS plant is well-known to botanists as the *Chamaelirium luteum*, and is one of the comparatively new remedies of our *Materia Medica*; it is an obscure treasure, its medical mysteries having never yet been fully unfolded. The native Indians were its custodians for a long time; it enjoyed a somewhat peculiar medical reputation among them and later among the white settlers of the country; still it remained for our learned explorers in scientific therapeutical research, Dr. E. M. Hale, of Chicago, and his coadjutors, to rescue it from its limited surroundings and place it for greater usefulness in homœopathic literature, as another gem in our therapeutic *diadem*.

Helonias is particularly suitable as a remedy for feeble constitutions, especially for females whose nervous system is run down, and who become easily fatigued; for the care-worn mother who tenderly watches over her family charge, as well as for the youthful maiden budding into womanhood. The results of its proper selection and application are brilliant and lasting, it is a peculiar and powerful *restorative*, it favors nutrition and promotes healthy secretions generally; in this respect it rivals the so-called tonics, and excels in the permanency of its effects.

I have found it of great benefit in sympathetic *gastric disorders*, when they accompany *uterine* or renal diseases. Its remedial effect will be agreeably surprising to those who are unacquainted with its action, when selected according to the indications laid down in our *Materia Medica*. It will cure cases of amenorrhœa and of menorrhagia whenever they are dependent on the same cause, uterine atony. It is an excellent remedy for cases in which there is a tendency to uterine malpositions; it is also useful in preventing miscarriage when from local weakness the slightest over-exertion produces its premonitory symptoms. In this respect it resembles *aletris*, while *caulophyllum* and *viburnum* are just the opposite and correspond to an irritable uterus, with great sensitiveness.

The successful treatment of many cases of atonic uterine hæmorrhage by *helonias* has led me to regard it as one of the best remedies for that condition.

The following cases will illustrate its action :

CASE I.—A lady, æt. 43, the mother of two children ; face pale and puffy, with darkness under eyes ; anæmic ; general anasarca ; confined to bed ; had been under old-school treatment for the past ten years ; during this time she had been flooding profusely at each monthly period ; was told by her physicians there could not be much done for her. When I first saw her she had a profuse discharge of offensive watery blood, and was so weak that she could scarcely be moved, while the abdomen was distended by ascites ; the uterus could be felt above the pubes. There was no indication of an ovarian tumor, nor of cancer, nor polypi.

After three months' treatment, with helonias as the principal remedy, she was discharged cured and remains in good health.

CASE II.—A lady, æt. 25, unmarried, suffered before and during each monthly period with pain in the back, suppression of the menses, the monthly congestion extending to the kidneys. Promptly relieved by the administration of helonias.

CASE III.—A lady, æt. about 33, married, apparently enjoyed good health, but suffered with uterine weakness and dragging sensation in the pelvic region, also chronic leucorrhœa. Was promptly cured by helonias, with the assistance of injections of three quarts of hot water at one time daily.

CASE IV.—A lady, æt. 30, after confinement did not gain strength, suffered from uterine atony and general anasarca. Was cured by the use of helonias as the principal remedy, and remains in good health.

MENTHOL IN PHTHISIS.—In the opening address in the section of therapeutics, British Medical Association, Brookhouse describes his method of using menthol in phthisis. Once or twice daily he injects into the trachea one drachm of a 12 per cent. solution of pure menthol in pure olive oil. This is effected by the aid of the laryngoscope and a syringe especially made with a curved tube ; the tube is passed through the rima glottidis, about half an inch down the trachea. After a little practice and habituation, the patient feels no inconvenience or discomfort whatever ; on the contrary, there arises an agreeable sensation of warmth in the chest. One very early result is a marked diminution of cough and expectoration ; the night-sweats, if previously existent, cease ; the hectic temperatures become less marked ; the curves often go to normal ; and the patients gain in weight.—*British Medical Journal*, July 30, 1892.

DERMATOL IN VENEREAL ULCERS.—Burtzeff has used dermatol in seventy cases of soft and hard chancres and incised indolent buboes, all in men. *The subgullate was used in powder* twice a day, or in cases of flabby and deep ulcers in the form of a 10 to 15 per cent. vaseline ointment. In the case of shallow ulcers and recently incised buboes, the discharge diminished and in some cases entirely disappeared on the second or third day, while the surface rapidly became covered with healthy granulations and very quickly cicatrized. Indolent or excavated ulcers healed somewhat less readily. The advantages of the bismuth salt are said to be these : (1) It induces far more rapid cicatrization than iodoform or naphthalin ; (2) it never irritates the surrounding skin ; (3) it is quite free from unpleasant smell or toxic effects ; (4) it is relatively cheap.—*British Medical Journal Supplement*, July 30, 1892.

EDITORIAL.

THE ACADEMY OF DENTAL SCIENCE AND HOMŒOPATHY.

The International Dental Journal, a magazine which by means of the energy of its editors and its management has placed itself in the first rank of dental journals, publishes in its September issue a paper by Dr. Charles H. Taft, entitled "Silica ; Its Curative Action in the Treatment of Alveolar Abscess." This paper was read before the American Academy of Dental Science, in Boston, April 6, 1892. On page 680 of the same issue we find the discussion on Dr. Taft's paper, a discussion that showed the paper to have made a most profound impression on its hearers. Those whose medical beliefs heretofore had not given them a knowledge of the remedy which Dr. Taft recommended, discussed the subject from the standpoint of liberal-minded men who were learning something new. If Dr. Taft's recommendations were good ones, they were anxious to determine that fact for the advantage of themselves and their patients. If his ideas were delusions and snares, then they recognized that their proper appreciation was best obtained by a fair and impartial consideration. We commend the discussion as a model to medical men. Where every one is anxious to learn the truth, dissension and discord cannot enter.

Dr. Taft's paper is a short one, and was devoted to a review of the scope of silica in the treatment of dental abscess, and the relation of homœopathic therapeutics to dental practice. The author, however, took good care to warn his hearers not to take the impression that equal success in the treatment of alveolar abscesses might ensue from the indiscriminate employment of silica as a specific in all forms of this pathological condition. For this, he said, is by no means the case.

In his remarks when closing the discussion, the author called attention to hepar and other remedies, and spoke in praise of Dr. Hering's domestic work as a reliable guide to the dentist who would become a practical therapist.

SOCIETY REPORTS AND THE LAY PRESS.

As a general principle, we must condemn the publication in the daily press of purely medical matters, and this for two reasons. In the first place the laity by reason of their lack of a medical educa-

tion misapply the information thus given, and so do themselves and their friends grave injury; and secondly, the medical man who gives forth the articles is very apt to be one who does it so that his good light shall shine forth before mankind, and thus exalt himself in the eye of the money-holding public.

With regard to medical society meetings, however, we think a little prominence given in the newspapers to their deliberations is a good thing, providing an unduly ambitious man does not seek to make his own remarks constitute about all that is good and praiseworthy in the society's proceeding. Such men are, of course, to be found in every association, and must be carefully watched.

We think it especially incumbent on our larger societies to see that reporters are courteously cared for, for unless this is done, they cannot be expected to be present and make proper reports. It not infrequently happens that these gentlemen are not accorded even the privileges of a seat, much less a writing table, in a convenient place, let alone the services of a member of the society whose duty it is to see that the information they obtain is well selected.

We must commend most heartily the many excellent reports of the recent meeting of the Pennsylvania State Society in Philadelphia, and the thoroughness with which its able secretary performed his duties without forcing himself upon the public eye for selfish advertising purposes. This example is one that should be followed by others who either do not get their societies reported at all, or else do so with every attention to self.

This question is of special importance to homœopathic societies, for at no time has a campaign of education been more important than at the present. Medical legislation is the order of the day. Ofttimes such legislation is vicious. The natural feeling for fair play belonging to Americans will kill such legislation if the people be but properly posted as to the merits of the questions involved:

THE DOSE OF NITRO-GLYCERINE.—Dr. George L. Peabody, in addressing the Practitioners' Society of New York, remarked that his experience had taught him, when giving nitro-glycerine for the relief of increased arterial tension, that an unfavorable result might be changed to a favorable one by increasing the dose beyond that ordinarily recommended, or until the desired effect was obtained. In support of this idea, he detailed cases where the dosage was increased until the patient was taking one grain of the drug every two hours, the ordinary dose being one one-hundredth of a grain. Absolutely no unpleasant symptoms followed the use of the drug. Other cases are met with, however, in which the ordinary dose produces considerable discomfort.—*Medical Record*, August 20, 1892.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D.,

FRANK H. PRITCHARD, M.D., AND EDWARD M. GRAMM, M.D.

PRIMARY CANCER OF THE DUCTUS CHOLEDOCHUS.—Dr. F. May, of Munich, Germany, reports a case of primary cancer of the ductus choledochus which is of great interest on account of its rarity and the ease with which it may be overlooked, in favor of some other affection. The patient was an official, sixty-seven years of age who, except suffering from renal colic had always been well. He had been a zealous hunter, a hearty eater and drank large quantities of beer. He had never presented any liver symptoms, much less been jaundiced. He first came under observation and was treated for degeneration of the heart muscle, with dilatation, stasis of the bronchi, and a resultant catarrh, as well as for a hepatic condition, due to stasis. He continued to fail through the last six months of 1890, and sought medical advice in May of that same year. Towards the end of January, 1891, he was seized with anorexia which increased in intensity, he being especially nauseated from the odor of meat. The liver swelled and the icterus became very intense, the urine of a dark brown color, containing a large amount of biliary pigment substances while there was great emaciation and loss of strength. The feces were light colored, clayey and had a penetrating odor, which reminded one of their smell after eating asparagus. His previous dyspnea, increased in intensity and he could not sleep. The respiratory symptoms improve under digitalis but the appetite, stools and icterus were uninfluenced. No painfulness in the hepatic region, neither on pressure nor spontaneously. Along in March there would set in, after any cause which would chill the body, attacks of chilliness. These often appeared at evening, for several days at a time. In April the patient was brought to his bed, he emaciated more and more while his appetite became less and less. The icterus still continued to an intense degree, the hepatic region was greatly swollen, insomnia, either from itching or without any apparent reason being present. The dyspnea became less prominent although the same general condition, with icterus, swelling in the hepatic region, anorexia and profuse sweating continued the entire summer of 1891. In the fall there appeared oedema of the ankles, scrotum, ascites and sleep could only be obtained by large doses of sulfonal or chloralamide. He became somnolent, did not know what he had just read or what the time of day was. His respiration often stopped to become again more rapid. Cheynes-Stokes respiration. In January, 1892, he was given morphine subcutaneously and his condition thereby somewhat relieved. On February he was suddenly seized with intense pain in the abdomen, vomited blackish masses, the abdomen being tympanitic and extremely sensitive to pressure with an elevated temperature. Death took place on the 7th of February, with symptoms of progressive collapse. At the necropsy a cylinder epithelial cancer was found at the entrance of the ductus choledochus into the duodenum, the liver filled with a number of grayish-white and lardaceous spots, of a brilliant appearance, and contrasting strongly with the surrounding tissue (metastatic cancerous nodes). The heart was moderately enlarged, degenerated; the common gall-duct was closed by the growth, the large gall-ducts being dilated and filled with a large accumulation of gall-stones. The gall-bladder was necrotic, inflamed and ulcerated, with perforation into the abdominal cavity. Consequent purulent peritonitis with inflammatory ascites. In such cases the diagnosis is very difficult. Schnepfel regards it as almost impossible. He sets forth as characteristic of the disease an intense icterus which continues uninterrupted and with all the symptoms of biliary stasis and swelling in the hepatic region, until death. The age and presence of a cachexia are also strong points in favor of the presence of a cancer. In the cases found in the literature the duration of life is fixed at four to eight months, although two have been known to last a year. The most of these died from intercurrent diseases (pneumonia), and but few from exhaustion. This

case perished from perforative peritonitis, due to perforation of the wall of the gall-bladder. The attacks of chilliness, were dependent on this ulceration of the gall-bladder. The presence of gall-stones is of ætiological importance. Heredity is no factor, individuals over the fiftieth year are generally attacked. The continuous and great loss of strength, the persistent icterus, as well as the digestive disturbances, anorexia, fulness and pressure in the region of the stomach, constipation with a colorless stool which would yield to no treatment, are the characteristic symptoms of this disease.—*Muenchener Medicinische Wochenschrift*, No. 33, 1892.

THE LYMPHAGENOUS DIATHESIS.—Prof. Jaccoud, of Paris, in a clinical lecture on a case of enormous tumefaction in the neck of a young girl, made a few remarks on the lymphatic diathesis. This swelling surrounded her neck like a collar. She was dyspnoeic, yet examination of the lungs and heart revealed nothing (mediastinal enlarged glands). The cervical glands of the right side were enlarged, but the remaining lymphatic glands were normal. Examination of her blood revealed a normal number both of white and red blood corpuscles. True leukæmia, he states, may be regarded as commencing when the proportion between the red and white falls to 1 : 50, or there must be ten times as many white corpuscles as are normally present. Forms of the affection are found where the number of blood corpuscles is decreased to 1 : 300, 1 : 200 or 1 : 100. These are nearer, in their general characteristics, to pseudo-leukæmia than true leukæmia. They may also be called intermediary forms, and, if the blood be examined every ten days, the number of white corpuscles will be found to have increased in number, so that the disease gradually approaches true leukæmia, if the patient live long enough. The lymphagenous diathesis presents two extreme types: true leukæmia and pseudo-leukæmia, the latter of which may kill without presenting any alterations of the white blood corpuscles. Yet these two do not exhaust the clinical pictures met in practice. There are certain cases which are in the transition stages, between pseudo-leukæmia and true leukæmia, which, if the patient be not carried off by the intra-thoracic tumors (mediastinal enlarged lymphatic glands) so liable to develop in these cases with accompanying dyspnoea and prove fatal, the affection passes over into true leukæmia. It is rare that the patient dies of progressive cachexia. The liver and spleen are especially liable to undergo changes, yet in this patient they were normal. Not only these organs, but also others where there is lymphatic tissue in the normal state, as the thyroid gland, the thymus, the tonsils, and the posterior wall of the pharynx, presented nothing abnormal in this case. These organs are the ones most frequently attacked, though not the only ones, for Rosenthal has designated the supra-renal capsules as susceptible, and, again, lymphoid tissue may appear in situations where it was not before present—hyperplasia neoplastic. True lymphoid heterotopic hyperplasia may arise anywhere, yet clinical observation shows it preferably to occur in the serous membranes, as the pleura, the peritonæum. The spinal canal has been the point of attack, this invasion becoming manifest by a paraplegia of which the pathogeny was elucidated at the necropsy. A careful examination is requisite in these cases, as the patient under consideration demonstrated, for she had albuminuria (renal localization) for over two years—a rare localization of the lymphagenous diathesis. The submaxillary tumors are usually soft, developing without change of the overlying integuments, which are easily movable over them. It is, hence, a pure lymphoma, and, what is characteristic of these growths, it is accompanied by pain. In this patient the glands enlarged at the age of six years, after a simple bronchitis, and remained in a latent state for eleven years, when, after an attack of pulmonary congestion, with bloody sputa, setting in as a complication of typhlitis, the disease was apparently disseminated and continued progressively to grow and develop. The lecturer advanced the fact that this disease is often dormant, and it is lighted up by a trauma or an irritative aggression upon a pre-existing gland. This is confirmed by many clinical observations; for example, Meyer records a case where, after removal of the tonsils in an individual who had a swollen lymphatic gland following tonsillitis, lymphadenia developed, with immediate swelling of the chain of lymphatics. In another subject an enlarged gland appeared in the submaxillary region after a number of attacks of gingivitis. It remained stationary for a long time, and, under the influence of carious teeth, an aggressive irritation, the disease developed. The knowledge of this fact is of great practical importance, for in this diathesis a gland may enlarge, and the temptation to remove it is great. It remains isolated for a long time and is disfiguring. The operation is performed, and forms the point of departure for the establishment of the disease.

The same results have invariably followed an attempt to remove the enlarged spleen in leukemia. In sixteen cases, where Nussbaum operated, all the sixteen died, while this operation, outside of leukemia, gives two recoveries to three operations. This case is of great interest, for the disease remained dormant eleven years, and, without the appearance of the pneumonia, it would have remained in that state for an indefinite time to come. Again, lymphadema may assume a slow course for years, and of a sudden spring into new life and kill in a few months or even in a few weeks. Examples of this are known. Fraenkel has reported a case where a young man of eighteen years succumbed to the affection in twenty days. The cases are very numerous where death has followed in five or six weeks. Westphal and Leyden have each cited cases where death occurred in two months and forty-three days respectively. These cases with a rapid course are generally accompanied by a febrile movement of a remittent character, associated with evening aggravations, and occasionally by intermittent exacerbations. Some authors claim a microbian origin for this disease, the present order of the day, yet it is by no means proven, and investigations of any number have been made.—*La Semaine Médicale*, No. 40, 1892.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

MODIFICATIONS OF GENERAL ANÆSTHESIA.—McBurney (New York) urges the more frequent use of what he considers a neglected method of modifying general anaesthesia (Corning and others). We anaesthetize too extensively as a rule, for, while it is only desired to narcotize the nerve centres, all of the tissues are saturated with the anaesthetic. To obviate this the blood is confined in the limbs by firm bandages. In ten cases the results were satisfactory; anaesthesia was induced quickly (two to five minutes) and quietly (without struggling); but little ether was used (one to three ounces); there was no congestion of the face, and but little vomiting or discharge of mucus. Consciousness returned quickly. This method tends to decrease shock, and kidney and bronchial disturbances.—*New York Medical Journal*.

ELASTIC CONSTRICTION AS A HÆMOSTATIC MEASURE.—Senn (Chicago) gives the results of an experimental inquiry into this subject in the following conclusions:

1. The use of the elastic bandage to secure a bloodless condition of a limb should be discarded, as mechanical dissemination of malignant tumors and microbic diseases may result.

2. A limb can be rendered bloodless before constriction by elevation with muscular relaxation (Lister).

3. Venous stasis is prevented by constricting quickly, beginning pressure on the side of the limb supplied with the principal bloodvessels. Both the venous and the arterial circulation should be interrupted at the same time.

4. The persistent capillary oozing following the removal of the elastic bandage is best treated by elevation of the limb when the constriction is removed, this position being maintained for at least six hours; by pressure; by heat (irrigation with water at 110° F.) or by hydrogen peroxide.

5. Too firm constriction may cause more or less permanent paralysis from nerve compression, or muscular injury. Linear constriction is especially dangerous, and hence the compression should be diffused over an annular space at least two inches in width. An elastic band or bandage is preferable to the Esmarch tubing.

6. Circular constriction of a limb should be made, if possible, at a point where the large nerve trunks are well protected, and, if this can not be done, a thick compress should be interposed between the constrictor and the limb.

7. The vitality of the tissues is endangered by excluding them from the circulation for three or four hours; gangrene may take place if constriction is continued for a longer time. The karyokinetic processes are unfavorably affected if the ischæmic condition is kept up for more than two hours.—*International Medical Magazine*.

MUSCULO-SPIRAL PARALYSIS COMPLICATING FRACTURE OF THE HUMERUS.—Murray (New York), records a case in which, by a secondary displacement of the

fragments, such pressure was made on this nerve as to impair its function. Incision showed it to be firmly adherent to and tightly stretched over the edge of one of the fragments; it was smaller, flattened out, and dark red at this point. The broken ends of the bone were freshened and united with silk worm gut. The symptoms of nerve injury were loss of supination, wrist extension, and radial flexion; wrist drop, and impaired extension and abduction of the thumb. There was some atrophy of the supinators and extensors but they responded to faradism; sensation was but slightly impaired. In eight weeks there was good use of the arm, and in six months a complete restoration of function. The writer finds ninety cases of this injury reported, most of them in the lower and middle thirds of the arm. The musculo-spiral is the nerve most frequently injured by fracture. It is usually compressed by callus or cicatricial tissue but may be contused or pinched by a fragment of bone. Complete division is rare. The results of operative interference have been most successful and the sooner this is undertaken the better. In four or five months after the injury contusion can be excluded, and relief by operation becomes the only resource. It is safer to expose the nerve at a distance from the point of compression, and to follow it up to the desired spot. In all fractures of the humerus an injury of this nerve should be looked for.—*Annals of Surgery*.

TREATMENT OF DELAYED UNION WITH CHLORIDE OF ZINC INJECTION.—Ménard used the chloride of zinc injection, according to Lannelongue, in a case of compound fracture of the tibia in which union had failed to take place after eight months of treatment. About a gramme of a ten per cent. solution of chloride of zinc was injected on the anterior and posterior surfaces of the bone, and between the ends of the fragments. Very severe pain was caused which is a drawback to this method unless an anæsthetic is used. Union was solid in one month.—*Revue de Chirurgie*.

[We have used this method in one case; compound, comminuted fracture of the right tibia; laceration of the anterior tibial artery; subsequent gangrene of the soft parts about the seat of fracture; delayed union after four months in spite of freshening and wiring. Injections of ten per cent. zinc chloride between the ends of the bone were followed by rapid and firm consolidation. The procedure was but moderately painful, no anæsthetic being used.—Eds.]

CLASSIFICATION OF HIP-DISEASE.—Lovett (Boston), suggests a clinical classification of the types shown by the common pathological process known as hip-disease. It will be of use in the prognosis as well as in the treatment.

1. *Destructive Hip-Disease*, due to a florid tuberculosis of bone, or to an acute, infectious osteomyelitis. The course is rapid, the symptoms severe, and but little influenced by ordinary treatment. The termination is usually death.

2. *Painful Hip-Disease*, due to the ordinary form of focal bone tuberculosis, with irritation surrounding the foci and a tendency to purulent degeneration. Pain is a prominent symptom, and exacerbations are common.

3. *Quiet or Painless Hip-Disease*, due to the fibroid form of focal bone tuberculosis, with but little irritation surrounding the foci and a tendency to the deposit of fibrous tissue. Pain is insignificant or absent. Malpositions are obstinate.

4. *Transient or Ephemeral Hip-Disease*, due probably to a tubercular focus which is either rapidly absorbed, or is located so far from the joint as to cause little or no synovial irritation. The symptoms are mild and it runs its course in a few months.—*Boston Medical and Surgical Journal*.

TREATMENT OF HYDROCELE.—Hearn (Philadelphia), suggests a combination of the Volkman (incision) and the Levis (carbolic acid) methods in the cure of hydrocele.

A small opening is made in the sac, which is mopped dry with sterile cotton. The tunica vaginalis is then thoroughly wiped with deliquescent carbolic acid; a small capillary gauze drain is put through the opening, and an antiseptic dressing applied. The gauze drain is removed in twenty-four to thirty-six hours, when inflammatory exudation ceases. Healing is more rapid on account of collapse of the sac, and the absence of effusion in the cavity and of infiltration into the scrotal connective tissue.—*Virginia Medical Monthly*.

TREATMENT OF GONORRHOEA.—Reverdin (Paris) recommends permanganate of potash irrigation in the treatment of gonorrhœa in all its stages. No other treatment is used, no untoward complications have been observed, and complete

cures have been made in three days, the average being fifteen days. The urethra is cleaned by having the patient urinate, and washed out by syringing with permanganate solution. A soft catheter is then introduced, not beyond the bulb of course, attached to a fountain syringe, and three to four pints allowed to run out of the urethra. The strength of the solution varies with the tolerance of the mucous membrane, one to five thousand being used at first, and its temperature should be about 110° F. The discharge practically ceases after the first two or three washings, but the treatment must be continued until all signs of inflammation have disappeared. The recommendation is based upon an experience of eight years.—*Revue de Chirurgie*.

TREATMENT OF CHRONIC GONORRHOEA.—Trzeinski (Warsaw) considers the instillations of Ultzmann and Guyon too severe for most cases, and, as almost all chronic gonorrhœas are due to involvement of the deep urethra, he recommends the more general use of mild nitrate of silver lavage (Neisser). A catheter is passed into the membranous portion and the posterior urethra and bladder washed by means of an attached hand syringe; it is then withdrawn until the compressor muscle is passed and the anterior urethra freely douched. This is repeated daily, beginning with a solution of one to eight thousand and gradually increasing the strength to one to three thousand. An olive-pointed, soft catheter is used. The discharge ceases in a few days, and the patient is considered cured when he can squeeze out a non-purulent drop and when the gonorrhœal threads are but few in number and present in the morning urine alone.—*Archiv. für Dermatologie und Syphilis*.

[We have used this weak nitrate of silver douche, anterior and posterior, quite extensively, by means of the hand syringe and the Ultzmann irrigating catheter, but without the same uniformity of success. Besides, we should hardly consider a patient cured unless repeated examinations of an occasional gonorrhœal thread showed no gonococci.—EDS.]

RUPTURE OF THE BLADDER.—Schlange (Berlin) records a case of intra- and extra-peritoneal rupture of the bladder successfully treated by operation. The patient was run over by a wagon while the bladder was distended. Laparotomy was done twenty-four hours after the accident. The peritonæum was cleaned by mopping, the intra-peritoneal tear sutured with catgut, the extra-peritoneal opening tamponaded with iodoform gauze. Cure, with good function of the bladder.—*Archiv. für Klinische Chirurgie*.

TREATMENT OF INOPERABLE MALIGNANT GROWTHS.—Carpenter records a case of inoperable sarcoma of the shoulder and axilla, following excision of the breast which practically disappeared under the following treatment:

R. Fluid extract of yellow dock, ℥j.
Water, ʒijss.

Of this two tablespoonfuls were taken three times a day, with the addition of a quarter of a teaspoonful of the following:

R. Fluid extract of pokeweed, ℥j.
Water, ʒijss.

The salve used locally was:

R. Fluid extract of pokeweed, ℥j.
Fluid extract of yellow dock, ʒij.
Yellow wax, ʒj.
Benzoated lard, ʒij.

The diagnosis was based on the microscopic examination of the primary, and the clinical picture of the secondary growth. When ulceration has taken place, the pokeweed must be omitted from the ointment. The tolerance of the drug varies, even the minimum doses (two drops) producing ill effects in susceptible patients. Coffee is the antidote and it should be abstained from unless needed to counteract untoward effects.—*Lehigh Valley Medical Magazine*.

CONVULSION TREATED BY COMPRESSION OF THE CAROTID.—T. G. Kelly successfully arrested a uræmic convulsion by this method (Roheim). The patient, a female of sixty years, was seized with convulsions which had lasted for an hour and a half, when she was seen. She was suffering from chronic rheumatism and renal trouble. After a few moments of pressure with the thumb on the carotid, which was beating with great force, the convulsions gradually ceased and did not recur.—*Lancet*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

INTRA-UTERINE ANTISEPTIC INJECTIONS AFTER NORMAL CONFINEMENT.—Dr. Keiffer reviews the subject, being particularly influenced to do so by syncope resulting in some cases reported by Tarnier.

He does not refer "to antiseptic injections employed in severe hæmorrhages in the puerperal infections, where their utility and marvellous action are abundantly shown, but to antiseptic uterine injections immediately after the completion of labor which has been in all respects normal." He reviews the three reasons given in favor of such injections as follows:

1. *To Empty the Uterus of Blood Clots which Fill It and of Débris of the Placenta Which can be Found There.*—Admitting that the examination of the discharges assures us of the complete removal of the placenta, as happens in the majority of cases, there remains nothing in the uterus then but blood more or less clotted, which the normal physiological contractions, as well as those brought about by frictions of the abdomen, expel spontaneously. The newly-formed clots which remain in the uterus serve to fill up the open sinuses, to constitute a barrier to the escape of more blood, to serve the rôle of an aseptic eschar, of a tampon most marvellously, and better than can be done artificially. The formation of a blood clot is the first expression of reaction on the part of nature. The filling of the cavity of the uterus with blood and the plugging of the cervix with a clot, produce the most favorable conditions for the prevention of relaxation of the uterine walls; the mass of coagulated blood serves as an intra-uterine aseptic dressing and also prevents hæmorrhage, and when the clot does not fill up the cavity of the uterus, made smaller by contractions, the relaxation of the walls is thereby favored, and hæmorrhage results. Intra-uterine injections, in breaking up the clot and the fibrinous lining of the uterus, provoke a new discharge of blood and dissolve the thrombi in the sinuses. Consequently, the end sought for should not be attained, as it is wrong to empty the uterus of its contents if these are normal and useful, and if there has been no infection through the hands or instruments, there is no authority to destroy, under the authority of prophylaxis, the repairing physiological actions of nature.

2. *To Excite Contractions of the Uterus, and in this Way to Reduce the Hæmorrhage to a Minimum.*—In the greater number of cases the uterus contracts spontaneously and without any intervention. If there is a tendency to inertia, light frictions on the abdomen or on the uterus, or even massage, are very useful adjuvants. But why institute in all cases methods of producing artificially that which nature brings about naturally in the majority of cases? Injections may be used, but one should wait to see whether nature is able to produce the contractions herself. But it is somewhat doubtful whether injections, as usually advised, do have any influence in producing contractions, for in a meeting of the Obstetrical Society of France, when cases were reported of syncope resulting from the entrance of the liquid into the sinuses of the uterus, it was advised that they should be given with less force. If so little force is used, then the breaking and washing away of the clots—one of the reasons given for such injections—is of no avail, as without force this cannot be accomplished. The explanation of syncope being the result of the liquid being forced into the sinuses is doubted by Dr. Keiffer, who considers it rather as the result of shock in many cases, and of poisoning from the antiseptic in others, though in some cases the liquid may be injected into the gaping sinuses.

3. *To Impregnate the Raw Surface of the Uterus with a Germ-Destroying Solution, and by this Means to Procure Prophylaxis Against Puerperal Infection.*—According to the teaching of Dr. Herman, we should avoid the use of antiseptic solutions in wounds which are not contaminated, as they destroy the superficial histological elements and render the surface more liable to an ultimate infection. According to Henrijean, we are taught that liquids called antiseptic are not so in reality, but are simply sterilizing solutions, playing a part purely mechanical in irrigations and injections, and this is particularly true about intra-uterine injections where it is so dangerous to use solutions really antiseptic, as the number of poisonings go to show. The possibility, then, of impregnating the uterine walls with a poisonous liquid without accident, and without rendering the surfaces formerly pure liable to contami-

nation and eminently fit for the development of colonies of bacteria, is evident, and a better method of infecting cannot be thought of than by the admittance of air.

Under the pretext of prophylaxis by intra-uterine injections, then, one risks the prevention of hæmorrhage physiologically; one destroys that which can oppose the relaxation of the uterus; one diminishes the vital resistance of the wounded tissues; one introduces air, an element which may be infectious; one risks equally to introduce by the fingers, by the sound, or even by the injected liquid itself, pathogenetic germs, notwithstanding the greatest amount of care. One cannot, then, deny that the abstaining from all applications may be more truly aseptic than using those which carry in their train so many dangers. These arguments are sufficient to reject on principle the use of intra-uterine injections after normal labors; but there is also another theoretic consideration that pleads for the expectant treatment. All physiological phenomena which occur in a healthy person should dispense with therapeutic methods. There is no more reason to wash out the uterus after a normal labor than there is to take an antiseptic injection after a stool, after menstruation or after an ejaculation from the urethra.

It must be added, however, that intrauterine injections and particularly mercurial ones are necessary in those conditions which are outside of physiological conditions, as in hæmorrhages, when simple methods fail to arrest it; when there is a menace of puerperal infection (fetid lochia), and every time that by the application of instruments or the hands, the uterine cavity has become liable to infection.—*Presse Medicale Belge*, 1892.

CAUSES AND TREATMENT OF SINUSES RESULTING FROM ABDOMINAL SECTION. Cases in which the peritonæum has contracted the habit of throwing out excessive secretion are favorable cases for the formation of sinuses after abdominal section. This is notably true in cases of tuberculosis of the peritonæum. Syphilis, malignant disease of the peritonæum, and disease of the abdominal viscera interfering seriously with the visceral or peritoneal circulation, are also predisposing causes. Chief among irritative agents are glass drainage-tubes, large or small, and too many or too large sutures or ligatures. A prerequisite to success is cleanliness. Irrigation should be practiced at least once a day, the preferable agents being simple hot water, hot Thiersch solution, or hot solution of creoline or carbolic acid. In all cases violence in exploration, injection, or irrigation, are to be rigorously avoided. We must not forget that we are in intimate contact with the thin and often friable wall of the intestine, and too much manipulation will almost inevitably result in a serious condition.—A. F. Currier, M.D., *Annals of Gynecology and Pædiatry*, July, 1892.

LAPAROTOMY.—Where shock and collapse follow a very severe operation, or when there has been much loss of blood, elevate the foot of the bed and inject about one drachm of the deodorized tincture of opium in a coffee-cup full of black, strong coffee into the rectum. The symptoms of hæmorrhage are increase of the rapidity of the pulse, its becoming thready and wiry, sweating and that terrible restlessness leading in many cases to violent delirium, and, often convulsions. Free diarrhœa relieves tympanitis, which undoubtedly produces vomiting. Often ox-gall in hot water, injected into the bowel in as large quantity as it can contain, will bring away large dejections of fæcal matter and gas, thus putting a new aspect on the patient's outlook. The writer cites an illustrative case. At the end of forty-eight hours, the temperature was 104°; her pulse 148, tympanitis was extreme, jactitation excessive, extremities cold and clammy. The patient was vomiting everything put into her stomach. The nurse was given to understand that the only possibility of saving this patient was to make her bowels move. After persistent use of large anæmas, containing turpentine, castor oil and ox-gall, she succeeded in moving the bowel. The patient passed enormous quantities of gas and fæcal matter, and in the morning her temperature had fallen to 100°, the restlessness had ceased, the tympanitis had nearly disappeared and the patient ultimately made a good recovery. A bowel movement should be secured in the third twenty-four hours at the latest. A combination of turpentine, castor oil, and inspissated ox-gall will usually answer every purpose. After this one may feel that the patient is practically out of danger. At each visit after laparotomy, the scrobiculus cordis should be examined for evidence of tympanitis. When the pulse goes up and the temperature falls the prognosis becomes more and more unfavorable.—J. H. Etheridge, M.D., *Annals of Gynecology and Pædiatry*, July, 1892.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY
CHAS. M. THOMAS, M.D.

THERAPEUTIC APPLICATION OF YAWNING.—In certain affections of the throat, such as acute pharyngitis, catarrh of the Eustachian tube, with pain in the ear, a Swiss *conférencé* says that he obtains excellent results from making the patients yawn several times a day. It produces, it seems, almost instantaneous relief, the symptoms rapidly subside, and the earache disappears. Frequently the affection is cut short by this novel treatment. Yawning produces, as every one knows, a considerable distension of the muscles of the pharynx, constituting a kind of massage, and under this influence the cartilaginous portion of the Eustachian tube contracts, expelling into the pharynx the mucosities there collected. According to M. Naegéli, yawning is more efficacious for affections of the tube than the methods of Valsalva or Politzer, and is more rational than the insufflation of air, which is often difficult to perform properly.—*Medical Record*.

THE INFLUENCE OF NASAL AFFECTIONS ON THE RESPIRATORY APPARATUS—CHABONY.—The author considers in what measure may be attributed to the nose certain varieties of asthma, of cough, sneezing, laryngeal stridor and glottis spasms, and what part it may take in the causation of laryngitis, bronchitis, tuberculosis of the larynx and of the lung, scleroma of the larynx, thoracic deformity and pulmonary emphysema.

On the subject of asthma of nasal origin, he sums up the different opinions, and concludes that inflammation of the nasal mucous membrane and obstruction of the nasal cavities form the point of departure of spasm of the respiratory muscles and paralysis of the vaso-motors of the bronchial mucous membrane.

Those in whom these symptoms are met with are nearly always gouty or neurasthenic persons. Constitutional treatment is required as well as local measures. Pollen, nervous temperament, and alteration of the nasal mucous membrane are the principal factors in hay fever. The diathesis must be treated first of all, and then the local trouble.

Certain cases of cough, sneezing, laryngitis (stridulous), glottis spasm are the result of nervous irritation. Laryngitis and bronchitis consecutive to nasal lesions are not rare; they may result from extension of inflammation from the nose, or be the consequence of atmospheric conditions.

Tuberculosis of larynx or lungs may be consecutive to a descending tuberculosis, which commenced in the nose. Nasal stenosis favors this occurrence by interfering with the air supply of the lung.

The nasal fossæ form a great barrier to the introduction of dust into the air-passages. In mouth-breathing, much of this dust is carried directly into the bronchial tubes.

Nasal obstruction may also induce depression of the chest, giving rise to depression or flattening of its lateral walls. Pulmonary emphysema may be a consequence of nasal affections resulting in paroxysms of reflex asthma, whose starting point is in the mucous membrane of the nose.—*Revue de Laryngol*.

INHALATION OF MENTHOL IN TRACHEITIS—For three years past Barbon and Martin have used warm inhalations of menthol in tracheitis. The menthol is placed in a flask with two tubulures and then placed in a water-bath. The menthol (melting at 38° C. and vaporizing at 45° C.) is inhaled. Only five or six inhalations can be made at the one sitting. The menthol in cooling is deposited on the mucous membrane.

Indications.—Laryngo-tracheitis with irritative cough. Laryngeal tuberculosis is a contraindication; in these cases intra-tracheal injections of menthol do best.—*Jour. de Med. de Bordeaux*.

EXUDATIVE LARYNGITIS—A SUBSTITUTE FOR INTUBATION.—L. L. Palmer (*Ontario Medical Journal*, September, 1892) suggests the removal of the exudation by means of a camel's hair brush on a platinum probe, the bristles pointing to the handle. This is carefully introduced into the larynx, as in intubation, and the membrane removed by the instrument or by the subsequent coughing. Instead of the brush, a probe wrapped with absorbent cotton may be used.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,

FRANK H. PRITCHARD, M.D., AND E. M. HOWARD, M.D.

NEPHRITIS AND ITS TREATMENT.—Dr. P. Jousset, of Paris, in his eighth lecture at the Hospital Saint-Jacques, took up the subject of nephritis and its various forms. Two varieties of nephritis are distinguished clinically, parenchymatous nephritis and interstitial nephritis. Parenchymatous nephritis, or catarrhal nephritis, is also called epithelial nephritis, as the epithelium of the tubuli is the seat of granulations of a varying form. The kidney is hypertrophic and pale—Bright's disease, with the large, white kidney. At its beginning this form is acute and is accompanied by a febrile movement and pain in the region of the kidney; the urine is scanty, often containing a small quantity of blood and much albumin. There is general anasarca, often considerable, from the very beginning. Soon vomiting, diarrhœa and epistaxis set in, the precursors of uræmia. Death may occur during the acute stage of the disease, yet it generally takes place from the uræmia, with convulsions, coma, dyspnœa, etc., or the disease may become chronic, with considerable anasarca, the patient perishing from pulmonary complications, hydrothorax, œdema of the lung, pneumonia or a cerebral complication of an uræmic nature. Curable at the beginning, yet if allowed to run on it becomes incurable, with death as a certain outlook. Parenchymatous nephritis is not interstitial nephritis, and neither is interstitial nephritis the terminal stage of parenchymatous nephritis, yet these two forms may run their course from one end to the other: the parenchymatous nephritis may pass over into the interstitial form, the mixed variety of Bright's disease. Every physician has observed cases of parenchymatous nephritis follow scarlatina, diphtheria or typhoid fever where the patient was apparently cured, and yet he succumbed after ten or twelve years from some uræmic complication. During all these long years the patient was seemingly well—no anæmia, no œdema, the urine was clear, abundant and often presented no traces of albumin. From time to time the patient suffered from violent headache, gastric disturbances and a certain degree of dyspnœa—a sure indication of the final fatal termination of the disease. In these cases the parenchymatous nephritis is succeeded by an interstitial nephritis, and the mixed form is before us. Damp cold is an occasional cause of the disease, yet some other affection, as scarlatina, diphtheria, being the chief affections followed by this form. The many varieties of benign diphtheria are frequently the cause. Typhoid fever and the cholera may also be followed by it.

Interstitial nephritis, sclerous or proliferative nephritis, is characterized anatomically by the formation of an embryonic tissue in the stroma of the kidney, which becomes organized and causes an induration and cornification of the organ. It is an actual sclerosis and is an incontestable localization of the arterio-sclerosis, the lesions being found not only in the kidney, but also in the greater portion of the arterial system. The symptoms are characteristic and totally different from the parenchymatous variety. Its beginning is slow and obscure, its progress slow and entirely chronic. There are a thirst and polyuria analogous to that of diabetes. The strength fails, the patient is anæmic, and the signs of hypertrophy of the heart are, for a long time, the only signs of its presence. The urine is pale, poor in urea, and at times presents traces of albumin. Anasarca is completely absent. These two latter symptoms are distinctly characteristic of the interstitial variety and are of differential diagnostic value. The signs of generalized arterio-sclerosis are also to be discovered. Interstitial nephritis, pre-eminently in its pre-albuminuric stage, gives rise to many errors in diagnosis. The decrease and loss of strength are attributed to heart diseases, gastro-intestinal affections, phthisis, cancer, etc. This disease is

especially frequent after the fortieth year, but it is not to be forgotten that it is also met with in those below that age and even in young children. It is caused by arterio-sclerosis, gout, alcoholism, lead poisoning, intermittent fever and syphilis. Its course is extremely slow and its duration very long, for the lecturer presented a case of a young woman who died ten years after the beginning of the disease. Its termination is necessarily fatal, as the lesion is irremediable. Prof. Lancereaux states that he does not know of a single case that was ever cured. The aim of the physician is to maintain the patient in good health as long as possible, which object is attainable by means of various hygienic rules and remedies.

The treatment may be divided into the treatment of the parenchymatous form, the interstitial form and of the uræmic accidents.

Treatment of Parenchymatous Nephritis.—Hygiene is of capital importance. Absolute milk diet. The patient should be kept in bed during the acute period stage of the disease, and he should not be allowed to quit the room as long as there is albumin in the urine. It may lead to a relapse and threatening uræmic convulsions. Yet if the disease become chronic, then the patient should be very careful in his going out much, as the damp cold is the greatest factor in producing an aggravation. If possible, he should live in a warm country, free from any dampness. The milk diet is to be held to if one hope for a radical cure. Few can continue the milk for an indefinite length of time; vomiting sets in, from the repugnance, and eggs and soups are to be added to his dietary. The eggs do not increase the albuminuria and the soups are to be made in milk, or even onion soup is allowable. A fatty bouillon is permissible in some cases. Alcoholic drinks and fermented liquors are to be interdicted, milk and water are the drinks. As to the meats, ham is the least injurious. On recovery, the patient should avoid all alcohols and only the slightest portion of fermented drink is to be allowed. Apium virus, in the sixth dilution, was in one case an energetically acting remedy. The quantity of urine increased from one-half to one quart. The sixth day of treatment the patient passed three quarts of urine, the albumin had decreased to one half grammes instead of four grammes, while the anasarca had considerably diminished.

Cantharis, in another case, was given in place of the apis, as the urine still contained a slight trace of blood. This drug, which produces in the normal man and animal not only the symptoms but also the lesions of acute parenchymatous nephritis, brought about a diminution of the albumin and the anasarca.

Tuberculine was then prescribed in the sixth dilution, and eight days after this had been prescribed the albumin had completely disappeared. Koch claims that his tuberculine does not act when given by the stomach, yet the lecturer has proven by experiments that this is not the case. Animal experiments have demonstrated that tuberculine has an elective action upon the heart and kidneys. Endocarditis and albuminuria, with the necroscopic lesions of this affection and parenchymatous nephritis are found. Hence, according to the law of similars, we are justified in employing tuberculine in the treatment of nephritis.

Treatment of Interstitial Nephritis.—The hygienic treatment of this form is based on the same principles as the preceding, only, that rest in bed and the continuous milk diet is not applicable to a disease of years' duration. Only in the uræmic crises is the diet to be followed in all its vigor. The modified milk diet, no alcohol, little beer and similar drinks, with the avoidance of cold and dampness.

Glonoine is one of the principal drugs in the treatment of this form. The writer has published a case where a cure was obtained from the use of this remedy. In a case, at present under observation, the daily administration of fifteen drops of the first dilution for eight days raised the urine to two litres per diem, the urea increased from 7 to 10 grammes, and the albumin fell in quantity from 2 grammes to one half gramme. During the relapse which this patient had, from leaving the hospital too early, glonoinine was without effect.

Iodium, in the third dilution, produces a rapid improvement, the urine increases in quantity and quantity, the albumin decreases, the convulsive state disappears, the vomiting ceases and the patient experiences a great amelioration in the relapses which occur after too early withdrawal from treatment. The lecturer was guided in his choice of iodine from two facts which are prominent in the pathogenesis of this drug—the production of albuminuria and vomiting from the administration of toxic doses. The clinical results confirmed the choice, for the albuminuria, in the case before mentioned, as well as the vomiting, disappeared under its influence. The action of iodine and glonoinine upon the arteritis chronic and the vascular ten-

sion which is associated with the disease is a reason which should lead the therapist to think of these medicines in the treatment of this affection. In small doses they augment the arterial tension, and their action is absolutely homœopathic. In the relapsing cases, tuberculine, either in the third or the sixth dilution, will cause the albumin to disappear from the urine and increase it in quantity. This drug produces in animals the large white kidney or the atrophic kidney, albuminuria and hematuria. In the heart and bloodvessels it causes endocarditis, affection of the mitral valve, with a souffle, arrhythmia and diminution of the vascular tension. In a heart case, with albuminuria, tuberculine 6x, caused the albumin to disappear. A man with parenchymatous nephritis acute, had the albumin disappear under its administration. In a case of broncho-pneumonia, of grippal origin, in a young girl, the albuminuria was cured by tuberculine in a few days. An arterio-sclerotic patient, with a vascular cardiopathy, which had been getting on well under the iodide of sodium, left off treatment for several months, and was finally attacked with incomplete hæmiplegia of the right side. The urine presented albuminuria in a varying quantity of .25 to 1.50 grammes per litre. The patient was placed on an absolute milk diet, together with arnica and belladonna. Under the influence of this treatment the paralysis diminished considerably, yet the albuminuria continued. He was given tuberculine, and in five days the albuminuria completely disappeared. The next day arnica was administered instead of the tuberculine, and a small amount of meat given. The albuminuria reappeared to go again in four days.

Treatment of the Uremia.—In one case where the convulsive form predominated, glonoine was sufficient. Inhalations of chloroform and injections of chloral, per rectum, are heroic measures. In the dyspnoic form all measures failed in one case under observation in the hospital. The iodide of sodium and the absolute milk diet produced a slight amelioration. Glonoine, the carbonate of ammonia and terebinthina also failed.—*L'Art Medical*, No. 8, 1892.

[Quebracho improved the dyspnoic symptoms in a similar case where I attended, yet only for a few days. Death rapidly followed.]—EDS.

THE SYMPTOMATOLOGY OF ACUTE LEAD POISONING.—March 3d, a woman, 30 years of age, presented herself at the polyclinic, in Leipsic. She was very pale, and bore a look of suffering. February 21st, while salting pork, she ate of it, and was seized with oppression in the stomach and diarrhoea, together with repeated vomiting, for which she took the next day a white powder, supposed to be the bicarbonate of soda, to the amount of six knife-pointful. The oppression of the stomach ceased and constipation set in. On the 23d she had flying pains in the abdomen, with swelling of the upper lip and left cheek, and accompanied by a burning pain. On the 25th the gums were discolored black between the incisors and first molars, being covered, especially the superior maxillary, with a fuliginous coating, intense, and which extended over on to the bases of the teeth. The mucous membrane presented five to six blackish-gray macules as large as one's fingernail, in the middle of which there was an ulcer two inches round and deep with a grayish covering. The teeth themselves were normal. The entire left cheek and the adjacent portion of the swollen cheek, upper lip swollen and sensitive to pressure. The tongue was covered with a yellowish coating and presented the impressions of the teeth. The saliva was increased in quantity and a very disagreeable fœtor from the mouth was noticeable. The abdomen somewhat swollen, very tense and sensitive to pressure in the epigastrium. Hard scybala in the sigmoid flexure. No defecation for six days. The urine contained a slight quantity of albumin, but without pigment, and containing indican. Lead colic was entirely wanting. The powder proved to be the carbonate of bismuth, with slight addition of bicarbonate of soda and magnesia. The case ended in recovery in six weeks.—*La Riforma Medica*, No. 10, 1892.

ACUTE GASTRIC CATARRH.—Dr. W. A. Haupt, in a paper read before the Ersten Berliner Homœopathischen Verein, of Berlin, presented the following remedies as worthy of confidence in the treatment of acute gastric catarrh:

Antimonium crudum, 3x.—Gastric catarrh, after sour wine or beer, with bitter and forcible eructations, the tongue coated white and moderate diarrhoea of undigested food.

Arsenicum album, 6x.—After fruit, salty or very cold foods and drink, with eructations, colic, thin and acrid discharges from the bowels.

Bryonia alba, 3x.—After catching cold or anger, with a yellow coated tongue, bitter eructations, pressure in the stomach, frontal headache and constipation.

Carbo vegetabilis, 6x.—After spoiled meat or fish, salted foods, emotional excitement, with insipid or rancid eructations, great development of gas in the stomach and intestines, constipation.

Ipecacuanha, 3x.—After catching cold, sour fruits, fatty foods, after immoderate indulgence of ordinarily digestible foods, especially during the summer, with insipid eructations, vomiting of food, bile, or mucus. Colic, with greenish, yellow, slimy, fermented or watery stools.

Nux vomica, 3x.—After indulgence in too large quantities of foods containing much starchy substances, or of wine, alcoholics or beer. Gastric catarrh after coffee, bitter drugs, with heartburn, white tongue and constipation.

Pulsatilla, 3x.—After rapid cooling of the perspiring body, wetting the feet, eating fatty, sweet or heavy sweet dessert articles, after cold foods, fruit, sour foods, or spoiled meat, with sour, bilious, or rancid eructations, with a white, yellowish, or slimy coated tongue, tympanites, watery, yellowish or slimy diarrhoea. If the thirst be severe, then give a teaspoonful of cold water every half hour. Constipation should not be allowed at all. Give a rectal injection of warm water; if this fail, add olive oil or soap, or a little salt. During the first few days, a light diet is to be followed, watery soups, as with improvement of the symptoms, add boiled milk, biscuits, rolls, rice, sago, soft boiled eggs and sliced and boiled apples. No meat is to be eaten as long as there are eructations. Even for a certain time after recovery the patient must be careful not to commit any errors of diet, or he may suffer a relapse. If the disease run into or assume that intense form known as gastric fever, the layman or the inexperienced usually gives aconite and is disappointed. Here the Schnessler remedy, ferrum phosphoricum, is indicated. Use the 6x, a dose every one or two hours, especially when all foods are vomited.

This state may be mistaken for typhoid fever, yet to the physician it is easily recognized, for the temperature soon falls, the palms of the hands remain moist and cold, a vesicular eruption appears on the lips, the enlarged spleen is wanting and the roseola as well as the dry and fissured tongue.

It is easily mistaken when the disease runs a long drawn out course.

To prevent a headache after a debauch, Katzerjammer, "big head," *nux vomica*, 3x, or if this has already been given, *carbo veg*, 3x, will be found of service.—*Leipziger Populäre Zeitschrift fuer Homœopathie*, Nos. 15 and 16, 1892.

TREATMENT OF GONORRHOEA.—Dr. Haupt, of Chemitz, Germany, treats gonorrhoea by injections and homœopathic remedies at the same time. He regards the nitrate of silver as the most efficient antiseptic for use in injections, and employs it in 1:2000–4000 solutions. It kills the gonococci with certainty, irritates the mucous membrane but little, and in the later stages of the disease it acts as a mild astringent. But in order to obtain the best results from the injections, which are given from the very first, one must dilate the urethra well by means of the injected fluid. One chooses a short, thick, and conically-ending syringe, so that the tip will fit well into the orifice. Then seize the glans immediately behind the orifice with the thumb and forefinger, while with the little finger of the same hand the penis is encircled at its root in order to prevent the fluid from reaching the prostatic portion of the urethra. The syringe is then taken in the right hand, the point introduced into the orifice of the urethra, and the fluid injected forcibly yet not rapidly into the urethral canal, while the thumb and forefinger of the left hand hold it in the urethra for fully three minutes. When properly done, on removing the finger and thumb the liquid should shoot forth like a strong stream. Otherwise, the injection should be repeated. The syringe should be cleaned carefully after each time it is used. In ordinary cases the injection is to be repeated three times a day. The injection may be made by the patient himself in gonorrhoea in the male, while in the female the physician himself should attend to the injection.

The remedy used in the injections should not injure the mucous membrane, nor increase the discharge, but destroy the gonococci. According to the experiments of Buum, very weak solutions are sufficient. Among the homœopathic remedies are:

Cerisee Sublimate, 6x.—The most appropriate remedy in the acute stage of the disease, especially in recent cases, where the patient has the disease for the first time. The patient is otherwise in good health, with very red glans, excoriations in the vicinity of the vulva, profuse, thick discharge, and much pain. *Mercurius*

nitrosus 3x is, on the contrary, more appropriate for those who have had the disease several times, and in whom the inflammatory symptoms are less pronounced.

Nitric Acid, 3x.—If much mercury has been given before.

Thuja Occidentalis, 6x.—Indicated in weak and scrofulous individuals, who are inclined to diseases of the mucous membranes.

Cannabis Indica, 1x.—For the continual desire to urinate, and the pains on urination.

Cantharides, 3x.—Indicated in the same symptoms as *cannabis indica*, but where these symptoms become intolerable, and, in the male, where there are very painful erections.

Later, when the redness of the urethral orifice decreases, the pains become less severe, and the discharge becomes less in quantity, more viscid and whiter, then one may employ *hepar sulph. cal.* 5x, or, *kali chloratum* 6x. The drugs which are of service in the treatment of the affection in its chronic stage are very numerous, and only are to be chosen after carefully considering the constitution of the patient, the lesser complications, and, above all, the character of the discharge. The right remedy is often to be discovered after the most careful study of the *materia medica* and many failures. Among those most frequently found of service are:

Agnus Castus, 3x.—Yellow discharge, in old sinners, and for the impotence.

Cubebs, 6x.—Mucous, milky-white discharge, in persons of a bilious constitution.

Natrum Muriacum, 6x.—Transparent, mucous discharges, or watery discharges, in chlorotic, constipated, or dyspeptic patients.

Phosphoric Acid, 6x.—In whitish discharge, in nervous or sexually debilitated persons.

Sepia, 6x.—In watery, or yellowish mucous discharges in those suffering from hepatic diseases, especially in hysteric women of a delicate constitution with a sensitive skin.

Sulphur, 6x.—In watery, whitish, or pale-yellow discharges in hemorrhoidal patients, and those inclined to skin diseases.

Thuja, 6x.—In watery discharges, in hydrogonoid constitutions.

Besides these, the following are praised: *Aqua silicata*, 0; *capsicum annum*, 3x; *hydrastis can.*, 1x; *kali sulphur*, 6x; *matico*, 1x; *naphthalinum*, 5x; *oleum santali*, 2x; *phosphorus*, 5x; *petroleum*, 0; *selenium*, 3x; *senecio aureus*, 3x, etc. As the posterior urethra is the seat of the pathological basis of chronic gonorrhoea, and is very inaccessible to injections, the homœopathic remedies will give better results than injections.—*Zeitschrift des Berliner Vereines Homœopathischer Aertze*, Bd. xi., Hft., ii.

FERRIC SULPHATE; RHEUMATISM, ETC.—A correspondent of the *Homœopathic World*, August, 1892, describes a case of involuntary proving of ferric sulphate. The patient was a man aged 55 years, whose work required him to set in motion by suction a siphon, in order to empty a tank around which green vitriol, or ferric sulphate, was crystallizing. The patient's tongue was as black as ink. He had frequently complained of a rheumatic, semi-paralyzed condition of the right arm and shoulder, a leading symptom of which was total loss of power to raise the arm level with the shoulder. From time immemorial a similar disordered condition had been observed amongst men who had that job.

In a married woman who had been persistently using steel pills, which consist mostly of ferric sulphate, every symptom of pulmonary consumption, hæmoptysis being a leading one, was produced.

In a poor boy, aged 14 years, whose face was, and had been for years, a mass of eczematous crusts, this powerful medicament, size of a pea, dissolved in a cup of water, teaspoonful doses after meals, effected a cure in a short time.

SILICEA IN CONSTIPATION.—Dr. Jos. T. Cook reports the case of Miss S., æt. 19 years, who had indigestion and severe constipation for two years. An attack of inflammatory dysentery (from a cold) left a marked inaction of the lower bowel for which gluten suppositories were used for two or three days, then a stool was had; but in two hours the patient was seized with a severe pain in the back and rectum, which was relieved by hot applications and "magnetic ointment" prescribed by the mother. Two days later another movement of the bowels, induced by a warm water *per rectum*, was followed by a renewal of the pain. She was so weak that she could hardly stand on her feet; on attempting to walk there was a great deal of pain *per rectum*, "like a knife cutting her," and when lying down on the

back it was a constant cutting pain. *Silica* 3x, gr. ij. every two hours, gave relief at once, and the bowels have moved without pain every day since.—*North American Journ. of Hom.*, September, 1892.

THE NERVOUS SYMPTOMS OF COCCULUS.—After giving in detail the principal nervous symptoms of *cocculus*, Dr. E. P. Colby makes the following remarks concerning the sphere of action of the drug.

The spasmodic symptoms would show it to have a marked action upon the cord and medulla, with a preference for the motor sphere, where its action is more of an excitant than true paralytic; *i.e.*, the symptoms in man are more those of spasm than paresis. Its paralyzing action when given to fishes cannot be directly applied to the symptomatology of the warm-blooded animals. It would seem to heighten the reflexes, although we have no careful physiological experiments recorded to demonstrate such as a fact. But, in evidence of this, there occurs in the symptomatology convulsions from wounds and traumatic tetanus. The symptoms of unilateral chorea would hardly be important until it can be made clear that it was a symptom produced by the drug and to what extent. By far the greater portion of the symptoms would indicate the benefit of the remedy in hysteria, as notice fainting in hysterical females, paralysis of the tongue, numbness of alternate hands and feet, with difficulty of speech during the attack, the various pains in the head, migraine, dim-sightedness. One will notice the peculiar symptom, spasm of the hand, as though one were writing, and also trembling of the hand when eating, with increase as the hand approaches the mouth. If these symptoms occurred in the same subject, we would have all that is necessary to make out a case of that rare form of paralysis agitans with tremor on voluntary motion. There is no evidence of a condition that could be put down as multiple sclerosis. More regular as an indication, however, is the group of noise in the ears, noise as of running water, with hardness of hearing, vertigo, with nausea and falling down unconscious.

The symptoms of tonic and clonic spasm, with semicircular and backward movements and rolling over on the axis of the body, which Hughes attributed to affection of the *crura cerebri*, Dr. Colby believes to be due to labyrinthine disturbance.

Cocculus gives great relief in the following symptoms which will be met with occasionally. A patient is taken "deathly sick" with nausea, and on sitting up the vertigo is almost terrifying. The countenance is pale, pulse slow and rather weak and the skin clammy.

Clinical experience is in favor of this drug in that form of occipital pain having its origin in a tired spine, and it is one of the most common forms of headache we are called upon to treat. The pain extends from the occiput, down the nape to the lower cervical region. In such cases *picrotoxine* seems to be more efficacious than the entire drug.—*N. E. Medical Gazette*, September, 1892.

TWO GLONOIN CASES.—Dr. J. W. Cartlich, of Kansas City, reports the following:

CASE I.—A woman, aged 39 years, gave the following symptoms from which she had suffered since girlhood: As headache came on, she would feel a rush of blood to the head, seemingly from all parts of the body; then she would become unconscious. One warm day, when about to enter a car, on returning home, she suddenly became blinded and forgot where she was. Then pain and throbbing appeared. It seemed as if her head had all the blood in the body, and then that the neck was squeezed so it could not return. She could not bear the least noise or jar. The only ease she could possibly get was to hold her head tightly with her hands. On moving her to a neighboring house, cold water was applied to the head, when she thought the head was being mashed in and fainted. On coming to she vomited profusely; then had relief. She would always be worse at her menstrual periods. It was learned that these attacks originated in a sunstroke a number of years ago. Glonoin 200 was then prescribed, with the effect of producing marked relief.

CASE II. was that of a young girl, 18 years of age. She suffered terribly with her head, holding it tight; she said she could not bear to be spoken to; she said her head would burst if she removed her hands from it: the throbbing in the temporal arteries was so great that they stood out like great cords; complained of her neck swelling; head hot, feet cold. Glonoin 200 in water was given; four doses, five minutes apart, gave her great relief.—*American Homœopathist*, October 1, 1892.

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THE USE OF ELECTRICITY IN DISEASES OF THE PROSTATE GLAND.

BY WILLIAM HARVEY KING, M.D., NEW YORK.

FOR a number of years there has been much written on the use of electricity in prostatic diseases, but so much of that which is claimed is found to be disappointing, that one is liable to become disgusted and abandon its use altogether. I might incidentally add that this disappointment is not only true of diseases of the prostate, but takes in a large field in electro-therapeutics. I have many times been disappointed in the use of electricity in diseases of the prostate gland. It cannot be too often reiterated that electricity has its special indications, the same as every other remedy, and, unless these indications are present, it is useless to apply the remedy.

The first disease that comes under our consideration is atrophy of the prostate; a very rare disease and one which I am not sure that I have ever treated. When we come to consider that the prostate is principally a muscle, the glandular portion only occupying an insignificant part, and that this muscular tissue is in structure analogous to the muscular tissue of the uterus, we might, considering the number of cases of atrophy of the uterus that has been improved by the use of electricity, conclude that benefit would occur for a similar condition in the prostate, providing, of course, that the cause of the atrophy is removed.

Some years ago I treated a case which was diagnosed by a phy-

sician other than myself as atrophy of the prostate. The patient was a man of about 40 years of age and had had stone in the bladder which had been crushed by a lithotrite. Some time before the operation he noticed, in having sexual intercourse, that the semen would not come out in jets as it had formerly done but would dribble out and continue after he had withdrawn. After the operation with the lithotrite it was found that this condition did not improve as it was thought it would and the diagnosis of atrophy of the prostate was made and the patient sent to me for electrical treatment. He was given three treatments a week, varying from ten to fifteen minutes in duration. The faradic battery was used. One electrode was introduced into the rectum and carried up to the prostate, the other, a flexible hand electrode, was pressed well forward on the perinaeum. The patient showed signs of improvement after the second week's treatment, and in nine weeks he had recovered to such an extent that the semen was all ejected before the penis was withdrawn. He considered himself cured and discontinued treatment. This case occurred in the early years of my practice and I did not doubt at the time that I had in twenty-seven treatments cured a case of atrophy of the prostate gland; but, from examinations made at the time and with more mature experience I now have doubts regarding the accuracy of the diagnosis; but still it might have been a case of atrophy of the prostate.

Hypertrophy of the Prostate.—In studying the subject of electrotherapeutics one of the most noticeable features is the great things that are claimed for it in those diseases in which other known methods of treatment are not satisfactory. This is particularly true of hypertrophy of the prostate. I noted over thirty different forms of application of electricity for hypertrophy of the prostate, the author of each one claiming great results. I wish to state here that after a large experience with nearly all the various forms of treatment that have been recommended, I have been unable to note any perceptible lessening in size of an enlarged prostate, and if it was not for the great patience of the organ much more suffering would be produced than is relieved by these various forms of treatment. As some of these treatments are yet used to a considerable extent, it is necessary that we should consider a few of them separately.

The passing of a galvanic current through the prostate by means of a rectal and perineal or rectal and hypogastric electrode is perhaps the most employed of any. The advocates of this treatment, as well as those who advocate puncture treatment, claim

that late researches in the pathology of hypertrophy of the prostate demonstrates that it is fibrous and analogous in nature to fibroid tumors of the uterus, and that it stands to reason that the same treatment should relieve one if it does the other. It should be borne in mind that in treating fibroid tumors we use strong currents varying from 75 to 250 milliamperes and that the principal action is the chemical galvanic caustic effect on the endometrium and very little of it is due to the interpolar action of the current. With hypertrophy of the prostate 15 to 20 milliamperes are all that can be used, and if it is carried to such an extent as to produce a chemical galvano-caustic action, we simply cauterize the lining membrane of the rectum and the result will be, as in two cases I have seen, an ulcer which is very difficult to heal. The puncture of the prostate and the production of electrolysis, which was advocated so strongly a few years ago, has lost the popularity that it once had. It is true that electrolysis of the prostate through the rectum can be performed a few times, with due care, without any particular harm; but tolerance of this form of treatment soon ceases, and no matter how much you relieve the rectal portion of the prostate, it does not remove the annoying and dangerous vesical symptoms which are the one thing to be accomplished in the successful treatment of hypertrophy of the prostate.

We believe, however, that if an enlarged prostate is ever to be reduced by electricity it will be by electrolysis, but it must be applied to the vesical portion of the enlargement. The galvano-cautery treatment of the urethral and vesical portion of an enlarged prostate is the most popular form of treatment just now. This treatment consists in introducing a sound which has a coil of platinum wire imbedded in the lower surface of the electrode, about one-quarter of an inch from the end. This sound is introduced so that the platinum wire comes in contact with the enlargement at the vesical neck, a current from a cautery battery is allowed to pass through the platinum coil, so as to slightly heat it, and thus cauterize the prostate. This treatment certainly has the semblance of being rational, but in every case that I have witnessed the symptoms have been aggravated instead of being relieved, and new symptoms of a very annoying and dangerous character have developed in four out of the five cases I have observed, and in one of the cases an acute inflammation supervened and this was followed by a chronic congestion, which made the life of the patient far more miserable than before the operation. While, as we

have stated, we do not believe electricity reduces the size of an hypertrophied prostate, we do believe that it can be used to advantage in certain conditions of prostatic enlargement. The treatment I use is generally given with the faradic battery, but the galvanic may be used. It is always best to begin with the faradic current, and, if it should not prove successful, try the galvanic. Great care should be exercised when this is done, and if any symptoms occur which indicate that the treatment is producing irritation, the galvanic current should be discontinued until all signs of the irritation has disappeared. I formerly used an ordinary rectal electrode, but of late I have used the electrode which I invented for the purpose, and which is represented in Fig. 1. It is covered with hard rubber,

FIG. 1.



which perfectly protects the metallic parts from coming in contact with the membrane. The end to be introduced has a small metal bulb inside the rubber sheath; in this sheath are narrow slits, and, as it is much larger than the metal bulb, it is absolutely impossible for the latter to come in contact with the folds of the mucous membrane, no matter how small that fold may be.

It is used as follows: Introduce the bulb well up into the rectum (about two inches), attach a Davidson's syringe to the projection seen at the lower surface of the instrument and inject water or a saline solution, which is forced through the hollow tube and through the slits of the bulb into the rectum. The patient will inform you when the rectum is full, and it is best not to inject too much, as it may be forced back by a spasmodic action of the intestines. This liquid acts as a conductor. The treatment given with this instrument possesses one great advantage: that is the current acts upon the whole surface of the rectum, or as far as the liquid has gone.

The other flexible hand electrode of large size is first placed over the perineum, and afterward over the hypogastric region. The whole treatment should last from eight to twelve minutes. The strength of the current, when the faradic battery is used should

be governed by the feelings of the patient, and that is, never cause distress; a slight bearing down in the rectum is sufficient, and it is just as well to stop short of this sensation. If the galvanic current is used, from five to ten milliamperes may be passed for the same length of time. Treatments may be given more frequently with the faradic current than when the galvanic is used. Ordinarily from one to three treatments a week will be sufficient. In order for us to understand the condition which we are to relieve by this treatment, it is necessary to take a look at the pathology of the disease. When we bear in mind that the blood returning from the vesical veins has to pass through the plexus surrounding the prostate on its return to the general circulation, we can easily see how any enlargement of that organ is liable to obstruct the venous circulation and thus cause a venous congestion of the bladder-walls and membrane.

This venous congestion, together with the obstruction of the free flow of urine, thus causing greater labor for the bladder-wall, at first causes slight hypertrophy of the muscular fibre of that organ. This hypertrophy, however, never entirely compensates for the obstruction, and soon the walls of the bladder are in a state of atrophy. As a consequence of this, mucus is thrown off, which makes the obstruction still more complete. Finally, the bladder is incapable of completely emptying itself. A sediment is left, the carbonate of ammonia is liberated, setting up a cystitis, and which, if the inflammation is allowed to go on, will follow up the ureters and produce a pyelitis. During all this time retention is usually a marked symptom.

Now, the treatment which we have given, if administered in the early stages, while it does not remove the enlarged prostate, it stimulates the walls of the veins, improving the circulation and removing the venous congestion of the bladder. It also stimulates the atonic bladder-walls, so that it can overcome to a great degree the obstruction, thus leaving less residual urine and lessening the liability of general cystitis. I have seen this treatment alone in the early stages of an hypertrophical prostate reduce the mucus so that it was only noticeable by carefully looking for it, when, before the treatment, it left deposits covering the entire bottom of a chamber, and it also decreased the frequency of urination from one hour to three hours. A case which came in my hands some time ago illustrates the benefit that may accrue from this treatment. A gentleman, 63 years of age, had suffered from hypertrophy of the prostate for three

years; that is, he had first consulted a physician three years previous, but he had suffered from a frequent desire to urinate some time longer, but no date of the beginning could be given by him. During his three years of treatment, before he consulted me, he had taken various medicines internally and had faithfully washed out the bladder with borax water once a day and had also drawn his urine once a day besides. When I first saw him he was urinating on an average of once in an hour and a half. The residual urine was from one to one and a half ounces and contained considerable mucus. The amount of enlargement was not great. He had discontinued internal medication for some time, and as I was desirous of not changing his treatment as far as medicine was concerned, so as to be able to judge just what benefit had been derived from electricity, I continued with the borax-water wash. Treatments were given with the galvanic battery every other day for three weeks and twice a week for six weeks. At the end of the tenth week the mucus had decreased 75 per cent., the intervals of urination increased to four to five hours, and the residual urine amounted only to from one to two drachms. The patient greatly improved in general health. After the tenth week he was treated once in three or four weeks with the faradic battery. He still continues the wash once a day, and is now living a very happy life, but I do not believe that the enlargement of the prostate has in any way decreased. Of course, when the posterior medium hypertrophy is great, neither electricity nor anything else will cause the base of the bladder to contract sufficiently to empty it entirely, but electricity helps.

Another very annoying condition which this treatment will generally relieve, either wholly or partially, is the rectal symptoms. These are of a large variety and are mostly reflex. It is, I believe, a universal law in the administration of electricity in organic diseases that the symptoms, both local and reflex, are relieved out of all proportion to the removal of the disease itself. The physician who has had no experience in the treatment of enlarged prostate may think that, as I do not pretend to remove the disease, the treatment is of little use; but to those physicians who have had experience and realize how great the suffering is and how thankfully a little relief will be received, I have no apology to make. I wish to state that this treatment is not intended to supersede the local and hygienic measures, such as keeping the bladder clean and the residual urine drawn off. It is only intended to supplement those measures.

Congestion of the Prostate.—Although the prostate is, when in its normal condition, a very patient organ, it is, when in a state of congestion, one of the most irritable organs of the body. Galvanism applied in any way is very liable to aggravate the symptoms of a patient suffering from an active congestion; but faradism given in the manner described under hypertrophy, particularly of the secondary coil, which is used, is made of a long, thin wire, will almost invariably relieve the distress temporarily; but I hardly think it is advisable to use it. I have, however, seen one case where the deposit thrown out by an inflammation was absorbed and the symptoms accompanying a chronic congestion relieved by the galvanic current.

The patient had been treated for stricture. Sounds had been introduced by a physician who evidently did not understand his business, for when the sound became obstructed in the deep urethra he forced it past the obstruction, using nearly his whole strength to do it and causing great pain to the patient. The next day an inflammation set in in the prostate but subsided in ten days without the formation of an abscess. Three weeks after this an examination by the rectum revealed a hard, unyielding mass surrounding the prostate, of a fibrous material thrown out during the stage of active inflammation. The prostate was only slightly sensitive on pressure. The patient felt a fulness and distress in the perinæum but no actual pain, and frequent desire to urinate. He also had a feeling as if he must have a movement of the bowels continually, but was unable to have any kind of a movement without an enema. There seemed to be a total inaction of the rectum. A small, flat, rectal electrode, which was first covered with absorbent cotton and then all covered with a tight-fitting piece of chamois, was introduced. This was before I used the water electrode previously described. The other electrode was placed on the perinæum and a current of ten milliamperes passed for five minutes. This treatment was given three times a week for two weeks and once a week for three weeks. During this treatment the deposit disappeared so that the cellular tissue became soft and yielding to the feel, the frequent desire to urinate disappeared and the rectum resumed its normal function. There is one more condition which I wish to mention, and that is follicular prostatitis, commonly known as prostatorrhœa. A case has recently come under my care which presented the following history: Two years previous he had an attack of gonorrhœa, during which he had symptoms indicating a congestion of the prostate, but which subsided after three

days' perfect rest in a recumbent position. After the gonorrhoeal inflammation disappeared there remained a slight muco-purulent discharge, and from that time until I saw him he had been treated for gleet, stricture and spermatorrhoea, all of which seem to increase the discharge instead of relieving it. The only inconvenience he suffered was a slight irritation of the vesical neck. He would occasionally notice a slight discharge in the morning and also at other times, but he noticed it principally after straining at stool. A microscopic examination of the discharge showed that it contained fatty debris, leucocytis and some prostatic concretion. The case was diagnosed as one of prostatorrhoea. A large-sized steel sound, No. 17, which completely filled the urethra, was insulated with rubber shellac to within two inches of the end. This was introduced so that the insulated part came in contact with the prostatic urethra. This sound was attached to the negative pole of a galvanic battery, the positive being placed above the pubis. Four milliamperes were passed for three minutes. This treatment was repeated every ten days until five treatments were given. At this time the vesical irritation had disappeared, the drop in the morning was no longer noticeable, but occasionally a very slight drop, very much less than before the treatment was given, could be seen after straining at stool. He now left the city, and, of course, treatment was discontinued. Whether more treatments would have entirely eradicated the trouble, of course cannot be told, but it is fair to suppose it might.

This is the extent of my recommendation of the use of electricity in diseases of the prostate, but I hope that with diligent work, in the near future its scope may be greatly widened.

THE INDIVIDUAL IN TYPHOID FEVER.

BY, W. C. GOODNO, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

THREE years since I had the honor to present to the American Institute a paper entitled "Considerations Relating to the Treatment of Enteric Fever." I at that time discussed some of the general principles involved in the therapeutic management of typhoid fever, devoting considerable space to its dietetic and adjuvant treatment. This paper contained a short analysis of two hundred

cases of enteric fever occurring in the private practice of the writer and extending through a period of seventeen years, the mortality being the smallest ever reported for a series of unselected cases, viz., $2\frac{1}{2}$ per cent.

As a supplement to that paper, I offer to-day some observations upon the individual in typhoid fever, being a consideration of the influence of the physical condition of the patient upon the clinical course of the disease. I must, of necessity, make some trite statements, but am consoled by the thought that such statements are often imperfectly absorbed on account of their very triteness. For instance, one has heard or repeated the Lord's prayer so often that it is mumbled with thoughts afar or listened to as a twice-told tale, exerting little influence upon our lives. So with the trite things medical. For instance, early to bed and most complete rest of body and mind has been so often repeated respecting typhoid fever that it fails to properly impress those who have not yet learned from experience its great importance.

I wish to say first something about the diagnosis of this disease. Its relation to subsequent statements will be apparent as we proceed. The importance of the subject cannot be overestimated, for it is during the first week of the disease, before the diagnostic criteria are clearly developed, that we gain our control of the case. I can not present the subject better than to quote from a paper which I presented to the Philadelphia County Medical Society, in October, 1877, entitled "Some Suggestions Relating to the Diagnosis of Typhoid Fever," and published in the *HAHNEMANNIAN MONTHLY* for that year. The conclusion of that paper is as follows:

"Finally, I would say that I consider it safe to assert that the vast majority of cases which are met in this region presenting symptoms of a continued fever, which has lasted for nearly one week, are typhoids; at any rate, they should be so considered and treated until another diagnosis can be clearly established. If enlargement of the spleen is present, the diagnosis is almost certain. Waiting for the development of the typhoid state, as so many do, is dangerous. Often there is an absence even of suspicion as to the true nature of the case until the presence of the typhoid condition, and I believe that a lack of a true appreciation of the nature of a typhoid in its first week is a prominent cause—yes, the prominent cause—of a large mortality. It is during this early period, when the leaven is beginning to work, that its ravages are inhibited by proper care, diet and medication.

"If you will allow me to be aphoristic, I will say, in conclusion:

"Don't forget the eruption at the close of the first week.

"Don't forget the enlarged spleen, usually discoverable at this time.

"Don't forget the great variety in the character of onset. It simulates other diseases.

"Don't lay too much stress upon the Wunderlich temperature range and gurgling and tenderness in the right iliac fossa.

"Don't forget the frequency of bronchitis and its early development in some cases.

"Don't forget that out of twenty continued fevers in this region nineteen are typhoid (if we exclude phthisis).

"Don't forget that other conditions do not "turn into typhoid;" that a typhoid fever is typhoid from the very beginning of the attack.

"Don't make too much of the bugbear malaria. Continued fevers of malarial origin are rare in this region.

"Don't depend on diarrhoea or be misled by cough."

Some of the statements in this quotation may seem arbitrary, but I hardly think they are exaggerations.

If the first great error in the care of typhoid fever usually consists in allowing the case to drift on for four to six days without even a provisional diagnosis of typhoid; a second error is, neglect to promptly study the patient, suspected of being a subject of this disease. (Note, "study of the patient.") Unfortunately, under such circumstances, even Hahnemannians of the purest type study the disease a great deal and the patient very little.

If a military officer intends marching his troops over a bridge—does he first examine his soldiers carefully, in order to determine their physical condition? No! he sends his engineer to examine the bridge, that weak points may be strengthened, and the structure made able to endure the strain that is to be put upon it. The moral is this—it is the duty of the physician, as early in the history of his typhoid fever case as possible, to search out with all diligence the condition of the vital organs, that he may know whether they are sufficient to "endure the strain" which is to be put upon them. I am satisfied, that a large percentage of the cases of aggravated typhoid fever which have had judicious care and treatment during the first week, occurs in persons presenting functional disorder or oftener, organic defects of these organs. The danger from typhoid fever increases with age. One eminent physician has said: "a man

is as old as his bloodvessels." If this be true, many are prematurely old, for many are possessed of diseased vessels. The centre of the vascular system—the heart—is the most important for examination, although the superficial vessels should be inspected, especially after middle life has been reached.

The principal conditions, warranting an unfavorable prognosis are :

1. Cardiac insufficiency, vascular degeneration—or both combined.

2. Mural disease, without enlargement of the heart.

3. The various organic affections usually attended by enlargement.

The heart furnishes the best evidence of the ability of the patient to withstand the effects of high temperature and prostrating disease; and a well-developed strong heart is a most powerful ally in the fight with this protracted fever. As our muscular systems differ in relative development, so our vascular organs differ in relative capacity and strength. This disparity can be detected by a careful and competent observer. The individual who has a heart of apparently proper size, but with an impulse which is not vigorous, who says, I can never run far or go up stairs rapidly without being short of breath; a heart which palpitates readily, and of whose actions the patient is conscious after moderate exertion—the heart pulsations being attended by a rather small radial pulse, seldom bear well protracted disease of a febrile character. More than anything else, it is the big strong heart that makes the successful racer; and more than any other factor, the strong heart carries the patient suffering from typhoid fever, through to final recovery. How important then to detect cardiac inability early, both for therapeutic and prognostic reasons. While the influence of an impaired circulation upon the organs and tissues generally is unfavorable the lungs suffer most. These organs early develop hyperæmia and their bronchial mucous membrane inflames—but these conditions are seldom in themselves a source of danger. It is that gradually increasing congestion in the most dependent portions, of these organs, which often leads to a hypostatic pneumonia that is most dangerous and which is due mainly to a weak heart. Rest, complete rest. Rest to the nervous system as well as the muscular. From the earliest days of the disease, viz., during that period when the doctor is often debating whether his patient is suffering from "cold," "biliousness," "gastric fever," "malaria" or "grip," does more for the patient than carefully prescribed remedies, or ounces of heart stimulants later.

ILLUSTRATIVE CASES.

CASE I.—A gentleman, 49 years of age, complained for a week of symptoms which the subsequent history of the case demonstrated to be the prodromes of typhoid fever. Upon my first visit I was struck by the feebleness of his pulse. Physical examination revealed a feeble heart impulse, but an absence of any other evidences of heart disease. Further examination during the succeeding day or two satisfied me that the man had degeneration of his heart and vessels. Upon the nature of the present sickness becoming clear, an unfavorable prognosis was made. The attack proved a mild one however, resulting in recovery, although the extreme feebleness of his heart's action at times occasioned much alarm. (I have repeatedly noticed mildness of attack in persons suffering from organic disease in some form.)

CASE II.—A professional man of 48 years, not overworked, or, as far as was known, suffering from previous disease of any kind, had been sick with typhoid fever for two weeks when I was asked by his physician to see him. The onset and progress had been mild, so mild that the best efforts had not been made to secure quiet. The one symptom causing anxiety, a symptom standing strikingly alone, was a feeble heart. This had been conspicuous from the early days. Death took place on the seventeenth day, clearly from "heart failure" (that much abused term). An autopsy revealed a rather small feeble looking heart, with diseased coronary vessels and fatty degeneration of the heart muscle. The aorta was atheromatous.

If the heart occupies an important relationship to certain symptoms of typhoid fever, the kidneys are scarcely less to be considered. The influence of defective excretion in developing the class of symptoms designated as the "typhoid state," has for some time been understood. But the influence of imperfectly acting kidneys in the development of aggravated symptoms referable to the nervous, mucous and serous tissues has not at least become the generally accepted fact which its importance demands it should be. The infrequency of urinary examination during the course of this fever accounts fully for the absence of information upon this subject. It is rare, indeed, that an examination of more than a casual sort is instituted unless symptoms of a strongly suggestive character are present. When made it is too often of a superficial character, such as a simple test for albumin in a dirty test-tube. Rarely is the specific gravity of the day's urine determined, sugar looked for, or the sediment viewed with the microscope. In ordinary uncomplicated typhoid fever the urine is generally scanty during at least the full development of the fever of high specific gravity, and may contain a slight amount of albumin. It often becomes free in quantity during the decline, with

a rather low specific gravity, which I take to be due in the main to the impaired renal epithelia which fail to excrete the normal amount of solids. If, however, at any time the amount of urine is abnormally large and clear, and if the patient is past early life and has a pulse which seems abnormally good when compared with the general condition of the patient, look for interstitial nephritis. The following short notes illustrate this form. Two years since a young physician in a distant State wrote me respecting a protracted case of typhoid fever under his care, in a patient 55 years of age. I replied, "forgetting your patient has typhoid fever, examine all the organs with care; the cause of protraction is probably a local one." By return of mail came the reply, among other things: "Urine, 64 ounces; specific gravity, 1006; albumin slight; hyaline and granular casts, some fatty; heart somewhat enlarged." Attention to the kidneys led to a slow recovery.

CASE III.—An old gentleman, 59 years, was under my care for typhoid fever. Great irritability of the stomach and a quiet sort of delirium with headache led to a urinary analysis. The evidences of interstitial nephritis were discovered. Death occurred in the third week with severe cerebral symptoms.

CASE IV.—Professional man, 33 years of age, hard-worked, nervous temperament. Walked during the whole of the first week. During the second and third weeks constant delirium, high degree of subsultus and several attacks of alarming failure of the heart. Early in the fourth week the temperature became normal, the mind cleared and there were all the evidences of convalescence, but without apparent cause the temperature again rose, the mind was clouded, delusions were present and general prostration rapidly increased. Early in the case the urine was found slightly albuminous. This disappeared with the subsidence of the fever and increased with the recrudescence. A careful search at this time revealed hyaline and granular epithelial casts. The specific gravity varied from 1008 to 1012, the color was normal and the quantity about 65 ounces. Convalescence was but very tardily established, and the gentleman is miserable now many months after.

CASE V.—Man, 37 years of age, sick with typhoid fever for three weeks. No indications of approaching convalescence, on the contrary, prostration, delirium and a bad state of the mucous track were prominent. The urine was probably about four pints during the twenty-four hours. Specific gravity 1035 and rich in sugar. Convalescence was but slowly established. Since recovery the evidences of diabetes continue, but are moderated by treatment. The presence of this disease was not suspected prior to the attack of fever.

CASE VI.—Man 44 years of age. Sick nearly four weeks with typhoid fever. Maximum daily temperature 103.4°. Mucous mem-

brane dry, red, denuded; diarrhœa; takes little food and that disagrees; delirium; all the indications of the "typhoid state" well developed. His physician says he has been highly lithæmic and a sufferer from flatulent dyspepsia and symptoms of functional liver troubles for many years. The urine contains a trace of albumin and much uric acid. Amount approximately two pints for twenty-four hours; specific gravity, 1028; no sugar; very gradual recovery.

Cases IV. and V. do not properly belong under this head, but for obvious reasons it is convenient to detail them in this place. The notes of the reported cases are necessarily too short to convey a proper estimate of the condition of the patients. But in each there was abnormality in course, and in most an improvement after proper attention was given to the cause of the troublesome symptoms.

May not the protracted prodromic stage, so frequently observed, be at times determined by the condition of the patient rather than the peculiar action of the specific element of the disease. I have made note of some observations upon this point, and will relate the following illustrative case:

A young man of 19 years, a student, who had "never been very strong," came to me feeling miserable. Malaise, anorexia, headache and other symptoms were complained of. A careful examination threw no light upon the case. One week later, symptoms remaining about the same, a urinary analysis was made: Quantity for twenty-four hours, thirty-eight ounces; specific gravity, 1024. Casts and albumin. Elicited a history of scarlatina four years previously, after which the feet and face swelled. I diagnosed chronic tubular nephritis, and treated him for another week, when fever appeared and he went to bed. One week later the typhoid eruption was present, much to my astonishment. The patient recovered from his typhoid after a tedious course. For more than two weeks this patient had been acutely sick with prodromic symptoms, but without fever. A failure to examine the urine would have prevented a true estimate of the case. Also the presence of the typhoid fever was not seriously suspected until the appearance of the eruption.

Since reading this paper a most interesting case bearing upon the subject discussed has presented itself. I will take the liberty of adding it:

Some eighteen months since a gentleman, 42 years of age, consulted me respecting his stomach. He had been under treatment

(allopathic), for more than a year previously, by an eminent physician of this city, with no improvement. Digestion was very feeble and painful, and there were symptoms of gastric catarrh of slight degree. A systematic physical examination revealed a very feeble heart, which fact had at least never been mentioned to the patient by his medical adviser. The pulse was small, rather slow and very compressible. The heart's impulse was feeble, but normal in position and free from murmurs and other evidences of organic disease. A sphygmographic tracing showed an insufficient ventricle. Mural degeneration was diagnosticated, and to test the correctness of the diagnosis digitalis tincture was given for a week, with immediate and marked relief of all symptoms, even those relating to the stomach. During the period of time intervening between that examination and the recent illness, commencing sixteen days since, he received agaricin 1x, sparteine sulph. 1x, strychnine 2x, and, for intercurrent symptoms, ign. 3x, cact. 1x and spig. 1x. Attention was given to diet, exercise, etc. Improvement was almost continuous, and during the past few months very little medicine was taken. Upon September 5th a sickness began which proved to be typhoid fever; and although the temperature was not high, and the pulse at no time before the last day above 108 to 112, and none of the evidences of aggravated typhoid fever present, an unfavorable prognosis was made and every precaution taken. Upon the fifteenth day the maximum temperature was 103.2°, the pulse 112 and good; there was mild delirium, moderate diarrhœa and restlessness. Upon the sixteenth day the pulse was 132 and very feeble; temperature 105.2°; skin of extremities cyanotic and cool and clammy. Death occurred the same evening, clearly from cardiac failure.

The structurally weak organ had endured wonderfully well until the beginning of the third week, but it had done all it could and stopped. The apparently good character of the pulse followed by such a sudden failure would have led one astray unacquainted with the previous history of the patient. Treatment in this case had improved the heart's nutrition and enabled it to do seemingly the work of a normal organ. But having been diseased, or being perhaps still degenerate in some degree, the progressive degenerative process was easily again established, requiring only sixteen days to develop incompetency.

Dr. C. R. Norton was in regular attendance from the first day.

LARYNGITIS.—Dr. Ragoneau calls attention to the development of catarrhal laryngitis in riders on bicycles and tricycles, which he attributes to the inclination of the body forward in speeding, to the necessity for mouth-breathing, and the access of air to the air-passages under pressure produced by rapid movements.—*Rev. de Lar.*, etc., No. 22.

SOME OBSERVATIONS UPON BRIGHT'S DISEASE, ESPECIALLY INTERSTITIAL NEPHRITIS.

BY F. F. LAIRD, M.D., UTICA, N. Y.

(Read before the Homœopathic Medical Society of the State of New York, October 5, 1892.)

A RECENT medical writer bluntly expressed a familiar truth when he wrote, "The grippé seems to possess the power of arousing all the latent 'cussedness' in the human anatomy." Its baneful influence upon previous cardiac disease is known to every physician; its equally pernicious effect upon latent renal lesions seems to have attracted far less attention. This oversight may possibly be due to the fact that many a case of apoplexy, phlegmonous inflammation and gastro-intestinal catarrh have been diagnosed as diseases *per se* rather than symptoms or complications of the insidious interstitial nephritis. Such an error can rarely befall the physician who makes it a rule to carefully examine, chemically and microscopically the urine of every chronic patient; but he who neglects these precautions will often find, to his chagrin, that he has been fighting the pickets while the enemy have captured the fort. As applied to the diagnosis of interstitial nephritis, the usual tests for albumin (heat and nitric acid), are as commonly employed, a snare and a delusion since the small amount of albumin present in this form of renal lesion is often passed by unnoticed. This fact has been so often brought to mind during the last year in a somewhat extensive experience with this class of cases that I cannot too emphatically emphasize it. In the urine of two patients who were under my care up to the time of their death, and where the diagnosis was confirmed by microscopic examination of the kidneys, no trace of albumin could be detected by the most delicate tests except at rare and infrequent intervals. Indeed the cases of nephritis without *persistent* albuminuria are by no means so extremely uncommon; and to this class belong, I am thoroughly convinced, a considerable percentage of the deaths of people over 60 years of age following the two epidemics of 1891-1892, and variously certified as "heart failure," "general debility," "apoplexy," "chronic diarrhœa," "hæmorrhage," etc.

A symptom in the male has so frequently called my attention to incipient interstitial nephritis that I am inclined to regard it as of great value in pointing to this lesion before any other sign is promi-

nently manifest, viz.: impaired or lost sexual power. This varies all the way from slight diminution of sexual desire to complete impotency. During the last two years, I have, in every case, made careful inquiry for this symptom and have so often found it present that its genuineness cannot be questioned. Its significance is fully as pronounced as in diabetes, and probably owes its origin to a cause common to both diseases. It is worthy of note, in this connection, that glycosuria sometimes, as in one of my cases, complicates albuminuria and thus renders the dietetic treatment of the latter anything but an easy task.

Chronic nephritis occurring in a patient previously suffering from "spinal irritation," frequently manifests itself in such a peculiar manner as to mystify the most acute diagnostician. In these cases, the full symptomatology seems to so centre upon the spinal cord, that the physician is almost forced into the belief that there *must* be present a meningo-myelitis to account for the severity of the symptoms. There are various neuralgic pains shooting out through the several spinal nerves.

Occipital and intercostal neuralgia, gastralgia, enteralgia, sciatica, etc., may alternate like the ever changing pictures in a kaleidoscope. Numbness and even "girdle pains" may be present; and yet there is no actual paralysis. Palpitation of the heart, dyspnoea and asthma appear in frightful intensity; but auscultation of the chest reveals no organic disease. In all the cases which I have seen—three in number—the ordinary flatulent, dyspeptic symptoms have been notably absent until a very late period of the disease. The spinal irritability seemed to be independent of the amount of urea passed; but was markedly aggravated whenever a too highly nitrogenized diet was used. The presence of an undue amount of uric acid in the urine was invariably the harbinger of a severe neuralgic storm. The patients from whose history the foregoing description is drawn were all males of nervo-sanguine temperament. One had acquired his irritable spine as a result of cerebro-spinal meningitis; in the other two, it was secondary to severe falls upon the coccyx. Medical literature, so far as my reading goes, makes no special allusion to this class of cases which are certainly very unique.

Whenever a large number of remedies are recommended in the treatment of a given disease, one may safely conclude that most of them are practically worthless. So we find it in interstitial nephritis. "Many are called, but few are chosen."

One remedial measure, however, has in my hands, nobly stood the

crucial test of clinical experience and given results far more satisfactory than any drug with which I am familiar. I refer to the systematic use of the hot-air bath. The apparatus employed is Ronchetti's over which is placed a wire cage invented by one of my ingenious patients to protect the bed-clothing from scorching.

A description of the apparatus, method of using it, etc., may be found in Millard's *Bright's Disease*, p. 217, *et seq.*

The frequency of the bath is regulated by the exigencies of the case and varies from twice daily to once a week. After the first trial, profuse perspiration is generally easily induced in from fifteen to twenty minutes, and is continued from thirty to sixty minutes, according to the patient's strength. Gin is given before the bath to prevent any feeling of faintness which might possibly be induced by the heat. After the bath, the patient is rubbed dry, bathed in alcohol and water, equal parts and then wrapped in hot woollen blankets. By this means, the danger of taking cold is effectually averted. For a long time I shared the common fear of administering this bath except to vigorous patients. A more prolonged experience coupled with a rapidly lessening dread of alcohol in nephritis, has thoroughly convinced me that the cases in which its effects are anything but salutary, are extremely rare. Given under the eye of a physician or carefully trained nurse, no danger need ever be apprehended. It is far safer and far more effectual than the hypodermatic injection of pilocarpine which so often produces distressing nausea and vomiting.

A STUDY IN MAGNOLIA GRANDIFLORA.

BY JOHN L. FERSON, M.D., PITTSBURGH, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

MAGNOLIA GRANDIFLORA (polyandria polygama) was proven by Dr. J. Talavera, of Mexico, and the proving published in the HAHNEMANNIAN MONTHLY for September, 1882. The symptoms of the drug, as presented in Allen's *Hand-Book of Materia Medica*, are made up largely from this proving. Magnolia grandiflora caused rheumatoid symptoms which secondarily affected the heart, and it is principally this action which we aim to study in this paper. It touches some of our well-known remedies at several points. It causes rheumatism, affecting the muscles and joints all over the

body, which does not seem to be of a highly inflammatory character; rather subacute. The pains attending are: "Soreness, stitches, stiffness and tiredness." Stiffness seems to largely predominate. The time of aggravation is in the morning, especially on first rising, after being quiet all night. The patient arises tired and stiff. The *tiredness* and *stiffness*, I conclude, are perceived only on motion, and as motion is continued the stiffness becomes less noticeable, and by midday wears off altogether. Before beginning to move, there is aversion to the thought, *soreness* is perceived when quiet but is decreased by motion, with the other symptoms. There is a strong rheumatic tendency; consequently, slight exposure to damp, especially in the form of a draft, causes a general stiffening up, while there is as decided and prompt amelioration from dry weather. In cases where only a part of the body is invaded, there is a strong tendency to erratic shifting of the pain and stiffness from joint to joint or from part to part.

This rheumatic stiffness may attack the right side of the chest, impeding respiration, and after lasting half an hour change to left side, attack the heart, produce fear of death, with coldness of the whole body, and paroxysmal attacks of suffocation. There may be rheumatic stiffness of both sides of the chest without the involvement of the heart. As less acute symptoms, there are stitching pains in the heart. They occur during the night, waking one frequently; in the morning on rising, disappearing in a short time; on breathing deeply; lying on the left side; also suffocation lying on the left side. These pains sometimes extend through the left side to the back, and alternate with pains in the left shoulder.

Clinically, there is recorded a numbness of the left arm, accompanying valvular defects of the heart. A peculiar accompaniment of the pains in the heart is itching of the feet.

The proving of the drug extended only over a period of thirty days. Had it been pursued further many more valuable heart symptoms might have been developed. It contains no record of altered heart action. Inasmuch as ten years have elapsed since the proving was published, would it not be well for Dr. Talavera to supplement his proving with the result of his further experience?

COMPARISONS.

Aurum met., in some respects, greatly resembles *magnolia*. Both have rheumatism characterized by stiffness, which, with *aurum*, is accompanied by boring or cramp-like pains. *Magnolia* awakes in

the morning stiff and sore, and is relieved by moving about. Aurum similarly awakes with pains in head and limbs, as if bruised, which pass off after rising. With aurum this is accompanied with numbness of limbs, as if asleep, insensible. Aurum, too, has an erratic rheumatism which passes from joint to joint, and finally may attack the heart, causing pain and great agony; pain extending along the left arm to the fingers; the action of the heart becomes intermittent, tremulous and irregular and the breathing short. The heart feels as if action had ceased, and then suddenly gives one hard thump. Aurum has sensation of internal emptiness; magnolia pain in the heart, with sensation of emptiness in the stomach. The general coldness, burning of the hands and feet, and aggravation from lying on the left side, of magnolia, do not appear. The aggravation from wet weather of aurum only applies to the asthmatic symptoms.

Dulcamara causes rheumatism with stiffness, but with it are many acute sharp pains, much more severe than the stitching pains of magnolia. Dulcamara has aggravation from being quiet more pronounced than magnolia, and instead of soreness when quiet it has keen, sharp, pinching, tearing, drawing or sticking pains. It has decided aggravation from wet weather. The erratic nature of the pains and the heart complications are lacking.

Lycopodium has rheumatism affecting all parts of the body, and stiffness is a marked feature, but, as with dulcamara, there are acute, tearing and various other sorts of pains, all of which bear the magnolia characteristic of being worse when quiet and relieved by continued motion, but differ in severity. Like magnolia it has burning in the feet and hands, but the resemblance goes no further.

Pulsatilla resembles magnolia, in having an erratic rheumatism, aggravated or caused by wet weather, and relieved by motion. The pains are drawing, tearing, tensive, unlike magnolia, but are accompanied by a stiffness similar to magnolia. Pulsatilla does not involve the heart.

Rhus tox. bears a resemblance to magnolia, both in its rheumatic and heart symptoms, but, while with magnolia the heart symptoms develop by an extension of the rheumatism to that organ, with rhus this is not the case. With both remedies there is very great stiffness of the affected parts; with rhus, accompanying the stiffness are jerking, tearing pains, which, however, are greater when at rest, aggravated on first moving, and ameliorated by continued motion, to be again aggravated after prolonged motion. With magnolia there is only a soreness felt when at rest, and on motion the stiffness is felt

with some stitching pains in the parts affected, and the relief from motion, which becomes more pronounced as motion is continued, till about noon all feeling of stiffness or soreness has disappeared, not to be felt again till next morning. The rhus condition is aggravated by damp or wet weather, or being in damp places. Magnolia aggravation is from even a draft of damp air. Rhus pains are not erratic. It has an organic affection of the heart with a tremulous sensation about that organ, sticking pains and numbness of left arm. It lacks the suffocation and pain when lying on the left side, the pain on deep breathing, pain shooting to back and shoulder, the constriction about chest, and other symptoms of magnolia.

Manganum aceticum has a rheumatism which, like magnolia, is erratic in its character, shifting about from joint to joint, aggravated by damp weather. It has, also, a cough, like that of magnolia, *i.e.*, "dry, incessant cough from irritation in mid-sternum, better lying down," caused by irritation in trachea and larynx. The magnesia cough is a sympathetic, dry cough during the day, relieved when going to bed at night.

Lachesis, so far as its rheumatism is concerned, does not resemble magnolia, except that it is aggravated by wet weather, but in some other respects there is a strong resemblance. The rheumatism of both remedies attacks the heart; magnolia has crampy or lancinating pains (clinical) in the heart, alternating with pains in left shoulder or spleen, pain in heart extending through to the back. *Lachesis* is only described as having anxiety about the heart. Both are accompanied by numbness of the left arm, and are aggravated when lying on left side; with magnolia, the pain in the heart and suffocation are aggravated, with lachesis, the palpitation. *Lachesis* has constriction of the heart, chest, and throat; magnolia has constriction of the chest, "as from a band around the chest on a line just beneath the axilla," and pain in the heart with constriction of the throat, with burning. *Lachesis* has, also, burning in the throat, but it is confined to the left side and throat-pit. Magnolia does not have the aggravation from, or aversion to, touch or pressure about the throat and chest as does lachesis. Both remedies have flushes of heat; magnolia, "heat and flushes with sweating," without the fainting or suffocation which are present with lachesis. Magnolia has *constant* burning of hands and feet. *Lachesis*, burning of palms and soles, *evening and night*, also, burning of the vertex. Both drugs affect the left ovary; lachesis causing swelling, induration, neuralgia, and suppuration of the ovary, with stitching, tensive pains, relieved

while menstruating ; with magnolia, there is congestion of left ovary with pain extending to the left thigh.

Lilium tig., like lachesis, has a constriction of the heart, described as a sensation as if the heart were squeezed in a vice, or as if grasped violently, alternately with feeling as if the grasp were relaxed. Like magnolia, the pain in the heart goes through the chest to the back. It also affects the left ovary, having burning, stinging, cutting pains which extend across the hypogastrium to groin, and down the leg, with sympathetic pain in left breast.

Latrodectus mactans, introduced in the *Homœopathic Recorder* of July, 1889, is worthy of study in comparison with magnolia.

Cactus grandiflora, because of its well-known constriction of the heart and chest, is brought into comparison with magnolia ; cactus having constriction of the chest and heart, magnolia of the chest and throat ; lachesis of the chest, throat, and heart, and lilium of the heart alone.

CONCERNING CLINICAL CASES.

BY W. J. MARTIN, M.D., PITTSBURGH, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, September 14, 1892.)

THERE has been considerable criticism lately, by writers in our school, not least among whom is that wise counsellor, Dr. J. P. Dake, on the subject of making and publishing reports of clinical cases. Dr. Dake is not in favor of publishing clinical experience, which he says is "a source fruitful of all manner of empiricism and uncertainty." That in what writing he has done in the course of his life, he has "seldom ventured to display cases and prescriptions for the very reason that prevented Hahnemann's doing so, namely, the faith one should have in the homœopathic law applied to pure pathogenesis. A knowledge of drug effects in the healthy, and a faithful comparison of them with the symptoms of each case presented for treatment, has seemed of infinitely more importance in practice than a reliance upon the revelations of clinical experience."

These are certainly words of wisdom worthy the thoughtful consideration of every practicing homœopath. First, a knowledge of drug effects in the healthy ; second, a comparison of these

with the symptoms of each case presented for treatment ; third, the administration of the drug whose effect on the healthy was the production of symptoms similar to those found in the case presented for treatment ; fourth, restoration of health ; this is homœopathic practice. The publishing of this work would be a clinical report.

As in all other departments of this life's work, we can and do have good and bad clinical reports. Bad clinical records are a bad thing, and are to be condemned. For example, such as where a writer gives his experience in treating la grippe, and says he treated so many hundred cases without a death ; that the remedies he employed were gelsemium, eupatorium perfoliatum, etc. Such a report is bad, good for nothing, and tends to produce empiricism by leading persons of little experience, or little knowledge of the principles of homœopathic practice to prescribe eupatorium or gelsemium for their grippe patients when the epidemic visits their locality, because they read in the journals that Dr. Bigpractice reported his experience with la grippe, and that he gave these remedies and did not lose a single case. These bad clinical reports are awfully numerous, some of our journals are at times filled with them, and the time of our society meetings largely taken up with them. Such reports do not teach, illustrate or demonstrate homœopathy.

But in good clinical reports we have a means of teaching, illustrating, demonstrating and verifying homœopathic materia medica superior to all other means. The clinics at our medical colleges are considered of the utmost importance in giving the students a thorough medical education. The announcements of the various colleges dwell particularly on the clinical advantages possessed by each one. Good clinical instruction seems to be considered a great necessity, and he who secures the greatest amount of it to be best qualified to enter upon the practice of medicine.

We are all students, or should be ; we are all learning, or should be ; we are all having our daily experiences, our successes, and our failures. We learn a great deal by our successes, and we sometimes learn something by our failures. Could our experiences, our additions of knowledge, be of advantage to others in the profession ? Could the experiences and additions of knowledge of others be of advantage to us ? Yes, if properly done. This, I think, is what we should consider as the field of clinical reports. Why should not I profit by the experience of those who have gone before me, and of

those who are living with me ; and why should not those who are to come after us have the benefit of what we have confirmed, verified or possibly discovered in the realm of therapeutics during the course of our experience ? But let the reports be made up in proper form ; let them give the symptoms of the case and the symptoms of the remedy corresponding thereto.

To become familiar with all the effects of all of our drugs upon the healthy organism by studying the provings and memorizing the materia medica, is one way of becoming a skilled prescriber,—a hard way, though a good one. But how often in our reading and studying do we overlook or miss points here and there which would be so firmly impressed upon our memories as never to be forgotten if brought to our attention by the report of a case presenting some peculiar or prominent symptoms for which a drug is prescribed, in whose pathogenesis these same symptoms are noted, and a prompt cure follows.

Well do I remember, a short time after I graduated, and when I did not know very much about very many drugs, that I read in one of our monthly journals a very short article from the pen of one who had been a member of the faculty of my college, in which he tells of stopping over night, when a young man, with some friends, who, I think, knew nothing of homœopathy. During the night he had an unexpected opportunity of illustrating homœopathic practice to them, as a member of the family was seized with an attack of most violent and alarming palpitation of the heart, the palpitation being so violent that the clothing could be seen moving up and down over the cardiac region. The doctor put a few drops of a potency of *spigelia* in a glass partly full of water, and after administering a few teaspoonfuls the heart quieted down and there was no more trouble. This little clinical case, happening to come to my notice at the outset of my medical career, so indelibly impressed on my mind this action of *spigelia* that I never forgot it. I have prescribed the remedy frequently under similar circumstances, and have many times, when witnessing its prompt curative effect, felt thankful to the doctor for having published that little clinical case, and sorry that we have not had the benefit of more of his valuable clinical experience.

VERATRUM VIRIDE takes the place of *aconite* in fever marking the onset of pneumonia, when there is great arterial excitement. The breathing is labored and difficult.

POSTURE IN LABOR.

BY M. S. WILLIAMSON, M.D., PHILADELPHIA.

(Read before the Homoeopathic Medical Society of the State of Pennsylvania.)

THE full title of the paper is "Posture in Labor and the Necessity of being Ambidextrous."

The attitudes of the mother and presentation of the child have been fully described, but little attention has been given to the relative position of the attending physician.

A pregnant woman has the right to demand the best attention in our power, and we are not only to deliver her safely and quickly, but we should allow her to select whatever position she may please, and we are, furthermore, at times called upon to suggest a change, so as to give relief to a weary worker.

Physicians who can use the right or left hand equally as well have a great advantage over those who are limited in a large degree to the use of only the right hand.

Medical history shows that at different times almost every posture has been recommended for the mother. In the early part of the present century Burns, a great authority in England, taught that the standing position was the most desirable, and gave as his reason gravity, saying it would have a better chance than in any other position, that the uterine contractions would be more constant, being excited by the pressure of the child.

With our present knowledge of the axis of the pelvis, it seems strange that this would be thought either safe or shorten the labor.

The child must be in danger from falling to the floor if the funis should be torn, whilst the mother must suffer from exhaustion, flooding, and in nearly all cases have the perinæum lacerated, and there would be great danger of inversion of the uterus.

If the woman is strong and wants to walk about the room there can be no objection, but how often we find them tired out by having followed the advice of some well-meaning but ignorant person.

There are two kinds of kneeling positions which have been practiced, the first with the head higher than the knees, the patient holding on to some article of furniture or to the nurse's hands, and the other with the face and knees resting on the bed.

The squatting or normal posture, Aveling says, "has been widely

used in all ages and places," quoting from Homer, where he places Latona in this position during parturition :

"When with her fair hand she a palm did seize.
And staying her by it, stuck her tender knees
Amidst the soft mead, that did smile beneath
Her sacred labor, and the child did breathe
The air in th' instant."

This position is not so dangerous as standing, and might be assumed by a woman without intelligent help, but would interfere with giving assistance.

The sitting position some years ago was very popular, and a great number of chairs and stools were invented, but, like the harness I have to show, are no longer in use.

The dorsal decubitus has been adopted in many countries, and is the common one at the present time in France.

In the first stage we can see the benefit, as it assists by gravity the descent into the pelvis ; but during the second stage, on account of the upward curve of the axis of the inferior strait, it must be a hinderance. The bed will also interfere with the dilatation of the perinæum, causing rupture.

The side or lateral position is the one commonly in use in this country, and, Proteus says, has been popular in England for over two hundred years. Pugh, of Chelmsford, England, in 1754, was the first to insist that it should be the left lateral.

The English recommend the lateral position both for version and when using the forceps, claiming for it no need for exposure or assistants.

The late Prof. Agnew was noted for his dexterity in operating, and, apparently, it made no difference to him in which hand he held the knife.

Charles Lever, the novelist, in an article in a magazine, called attention to our one-sided education, and Hammond says that we bring into action only one side of the brain, but there is no good reason why we should not make as much use of the left hand as we do of the left foot.

The only thing about pugilism we can admire is the cultivation of both hands. Exercise with dumb bells and Indian clubs will do much towards developing the muscles in both arms equally, and, for finer work, learning how to shave with either hand is to be highly commended.

Persons who have injured the right hand have in a short time learned how to write with the left one.

Both hands can be of great use in assisting the delivery of the child. The right one may be used to dilate and support the perinæum when the left hand is placed in front of the patient, and seizing the head, if that part present, press it against the symphysis, continuing the extension, and after the head is born, grasp it and draw the child up in front of the abdomen, at the same time assisting with the right hand, thus working in the axis of the pelvis and taking much strain off the perinæum.

In cases where it is necessary to prevent the too rapid delivery, on account of dilatation not being complete, the left hand should be placed in front and around to the thigh of the patient, and an easy and firm hold of the wrist of the right hand will give efficient support.

The pillow between the knees is much in the way, and the nurse, by raising and keeping the upper leg flexed, can render great assistance during the expulsive stage.

It is to be hoped that in America the women who find it more comfortable to lie on the right side may be humored in this respect. It becomes the duty of the physician to learn how to make use of the left hand as well as he does the right one.

NITRITE OF AMYL VERSUS CHLOROFORM.

BY C. H. HUBBARD, M.D., MILLVILLE, N. J.

IN the September number of the HAHNEMANNIAN MONTHLY, Dr. J. C. Cummings of St. Louis, Mo., has an article on "Nitrite of Amyl versus Chloroform." The doctor very correctly suggests the use of amyl nitrite by inhalation when "alarming symptoms" occur during the administration of chloroform.

The characteristic, pathognomonic symptoms of nitrite of amyl, unmistakably point to its use in chloroform narcosis, and it is neither necessary nor wise to wait until "alarming symptoms" occur before the nitrite is exhibited. It is as a *prophylactic* agent I can confidently recommend it. Its action is purely homœopathic, as a brief *résumé* of its characteristic symptoms clearly prove. Note in its provings—through its action on the vasomotor nerves—the

dilatation of the arterioles and capillaries, as shown by the flushed face, the tumultuous action of the heart, though weakened in force; the throbbing carotids; the small and feeble pulse; oppressed respiration, at times irregular, spasmodic and stertorous; convulsive sighing; eyes glassy and staring, are symptoms that unmistakably indicate its value in dangerous symptoms from chloroform narcosis.

In 1884, acting upon the suggestion of Dr. M. D. Youngman, of Atlantic City, I began the use of nitrite of amyl as a prophylactic for the possible dangerous effects accompanying the use of chloroform as an anæsthetic.

The mode of administration is to add three to six drops of the nitrite to an ounce of chloroform and proceed in the manner usually adopted.

With the above combination, the danger is reduced to a minimum, and I have never known untoward symptoms occur when chloroform and nitrite of amyl were thus employed.

CLINICAL VERIFICATIONS OF PHOSPHORUS AND HELLEBORE.

BY MARY BRANSON, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

DR. O. W. HOLMES says "apology is only egotism wrong side out," hence no word is offered in defense of this meagre paper. The cases recorded within were of peculiar interest to the physicians in attendance, and seem worthy to be brought to the notice of others.

An interesting phosphorus case was Anna S., æt. 10 months, a fat, healthy, sunny child, fair skin, dark hair. March 10, 1890, commenced to be fretful, pale and nauseated. This continued for three days; ipecac was given with but slight relief; 22d, still pale and sick, arsenicum was administered, followed by great improvement for three days; 27th, again pale and drooping; 29th, again better, this condition continuing, although perfect health was not restored. April 25th she took a severe cold, seemingly a mercurius cold, and again May 10th. This time the arsenicum coryza was marked and symptoms were like the grip, which three of the family were suffering with at the time. Arsenicum made little impression, and pulsatilla was advised. On the 17th croup symptoms developed violently, and aconite and spongia did not touch the case. Breath-

ing was violent, bronchial tubes much filled, symptoms growing worse hourly. Child apparently unconscious, cyanosized and in agony. Every muscle was called in action to assist breathing. At 11 P.M., while called away to another case, a doctor living near was called in and administered bromine. On my return to the house at 5 A.M. the child was still living; nothing more encouraging could be said. Counsel was called, and from the white skin, cold extremities and inability to take any but cold food throughout the illness, we decided upon phosphorus. Aggravation ceased in half an hour. A shade of improvement in the breathing was the first gain. From this time the progress was steady until she was perfectly restored to health, and she has had no illness of any kind since. Large pieces of membrane were coughed up with ease during her recovery. It had been seen completely lining her throat at several different times during the violent symptoms. There was much teaching in this case to me, and I feel ashamed to acknowledge that some lime was ready in the house and various implements in case the little pills should fail. Truly we have good reason to trust them in the desperate as well as in the mild cases.

Alfred L. was born July 14, 1888. His parents were young, healthy and living in a healthy locality. He was a small though well formed child, weighing five and a half pounds, and seemed in a fair way to prosper. This was a surprise to his parents, as Mrs. L. had received a severe shock a short time before his birth. My first acquaintance with Alfred was on Thanksgiving day, 1888. He was four months old, weighed eight pounds, and was little more than a skeleton. He had spent most of his life crying from hunger, as no food was retained long enough to nourish him. Different preparations had been tried, but vomiting and diarrhœa attended all alike. A wet nurse was no more successful.

At this date his remedy was calcarea, with sterilized milk and barley water for food. He gradually improved so that in four months he had doubled his weight. On the 2d of March he was seized with a convulsion causing great surprise and alarm. A neighboring physician was called in who considered it an attack of indigestion. He had the barley decreased in his food and the milk more diluted. Convulsions occurred at intervals of one and two hours all day. Acute brain symptoms developed and the case was soon found to be one of hydrocephalus. His head increased in size, eyes protruded and suffering was severe. The attack was violent; he had thirty-seven convulsions in all, but they all yielded to hellebore

which was clearly indicated. By the last of March he was able to be taken to Atlantic City and had only one convulsion while there. He now seems perfectly well though one slight convulsion occurred in October, '89, and one in March, '91, when from a severe cold he had pneumonia. This attack commenced with a congestive chill and convulsion, but he recovered promptly from the illness under phosphorus. His head is abnormally large, he is extremely bright and talked well when two years old. At the time Alfred was taken with the first convulsion his mother was holding him in her arms, and having never seen anything of the kind, the impression upon her was something terrible. She felt the shock through her whole system. Seven months after this date the second son Edmund was born October 2, 1889. He weighed nine pounds and was a well formed, perfect baby. Labor natural. He had good health and seemed a most attractive child up to January 6, 1890. At this date he had fever, temperature 102° , pulse rapid, face pale, throat ulcerated; belladonna promptly relieved. A similar attack occurred January 20th soon relieved by belladonna. On January 24th at 5.30 A.M., with no premonitory symptoms he was awakened from a sound sleep with a convulsion. From this time he rapidly grew worse. In the following twelve hours he had nine convulsions. He was blue-white both during and between the convulsions, face and body looked shrunken, eyes closed part of the time or else half opened with internal strabismus, no expression in eyes, no response of pupils to light, no cognizance of noise except when asleep, a sudden sound would rouse him and throw him into a convulsion. Skin hot and dry, spine rigid; we could with one hand grasping his feet lift him clear off the bed as if he were a piece of wood. Abdomen distended generally. Breathing was quick and caused slight movement in chest. Later in his illness it was often difficult to see if he were breathing at all. No sensitiveness over body generally. At times he felt pressure over the base of the brain, especially toward either side. The bones of the skull were more prominent back of his ears. Tongue red, slightly coated. No salivation, no vomiting. Discharges from the bowels were frequent, scanty and well digested, and occurred often during a convulsion. Kidneys acted well, no specimen could be collected for examination.

By 6 P.M., January 27th, he had thirty-seven convulsions. There was deep sleep or stupor between the attacks, and no loud, sharp, crying to this time. Temperature ranged from $96\frac{1}{2}^{\circ}$ to 102° during his illness. Opisthotonos strongly marked. He could swallow suf-

ficient nourishment by careful feeding with a spoon. On the night of the 25th sinking spells occurred, when the child would seem lifeless for hours together. At the solicitation of the parents counsel was called at 2 A.M., and opium was agreed upon. Previous to this hellebore had been the remedy depended upon. January 26th the spells of apparent coma were shorter and fever was marked, temperature as high as 102° ; the night was the same as the previous, long sinking spells when life frequently seemed extinct. January 27th, baby slightly better in the morning, night just the same. January 28th, no change except a violent sinking spell at 5 P.M. For the two days following there was a little gain, less sinking spells, and two days with no convulsions. On the 31st the condition was somewhat changed. If he was not in a deep sleep or stupor he was crying. This crying was peculiar. It was not that of colic, hunger, or ill temper, nor yet the "cri hydrocephalique," but every moment he was not in a stupor he kept on a steady, hard, measured, suffering cry which was unnerving to the most callous listener. Seven days this continued with no abatement; at times he rolled his head and bored it into the pillow. He could swallow his food, but appeared to know nothing about it. No convulsion from January 27th to February 5th, when he had three severe ones, 8th and 9th some improvement from belladonna 3; 10th, three more convulsions; 11th, three convulsions; 12th, called at 1 A.M. to find Edmund in an apparently lifeless condition; different restoratives were applied and he revived. Apis seemed clearly called for and was administered. Convulsions at intervals all day, but expression of face was better between them and he was quiet; 13th and 14th, some gain in all the symptoms; 17th, baby resumed his crying; 18th, 19th, and 20th, still crying.

Counsel was called and stramonium ordered; 21st, crying, with short periods of rest; 23d, four convulsions; 24th, two convulsions; 25th and 26th, slight improvement; 28th, one convulsion and a crying day. Still under stramonium. Early in the sickness (either the first or second day) after the convulsions commenced circumcision was performed by a surgeon who was a personal friend of the father. The healing was fairly prompt, but no change in symptoms followed the operation. March 1st, baby improving, on the 4th he moved his head and hands in a natural manner. Mr. L. had his own physician see the baby, and he prescribed cicuta. Improvement steady from this date until March 26th, when he had one convulsion.

April 4th, one convulsion; 5th, one convulsion; 6th, two con-

vulsions. Improvement uninterrupted from this date. Occasional doses of psorinum or calcarea were all the medicines given in the last few days. April 17, 1890, the family moved out of town. Once after this, August, 1891, he awakened with a cry and showed every sign of having had a convulsion. The total number from January 24th, was eighty-three.

His present condition is peculiar. He is a fat, rosy, handsome and attractive child. His flesh is firm and his strength excellent. He is intelligent in appearance, always good tempered, plays happily, but prefers to play alone; shows great perseverance in all his undertakings, but as yet he makes no effort to talk, though he will be three years old in another month. His hearing is acute, his throat is well formed, "papa" and "mamma" are the only words he has said, but he says them distinctly. He has spells of laughing at some trifle. He will commence suddenly and laugh long and heartily and then stop just as suddenly as he commenced. These attacks worry his parents, but no physician has seen him have one. His understanding seems excellent. Of the different physicians whom his parents had called in at different times to see the case with me, each thought at first of injuries from a fall, but no accident of any kind could be traced. The diagnosis differed with each physician. January 10, 1891, a third son was born to Mrs. L. This boy is large, well developed, has perfect health, never had a day's sickness, is hearty and talks merrily.

One fact we have ever to hold before us, that however important it is to make a correct diagnosis it is not on this fact that we hinge our prescription. Surgeons always excepted. No intelligent physician depreciates the importance of diagnosis. Its value for the satisfaction of himself and of the patient's friends, for the hygiene and nursing of the case, for the proper protection in cases of contagious diseases and for all reasons except for the prescription. Only the totality of the symptoms corresponding to the drug administered will cure the patient.

THE INDICATIONS FOR VENTRAL FIXATION OF THE UTERUS—WOLF.—Twelve cases are reported with one failure and one death. The first cases were operated on by Olshausen's method but later after that of Czerney-Leopold. Ventral fixation is indicated for fixed retroflexions, mobile retroflexions causing severe complaints and neither massage nor pessaries afford relief, and for severe prolapsus to further strengthen the support of the uterus when repair of the pelvic floor by plastic operations is insufficient.—*Centralblatt für Gynäkologie*, No. 35, 1892.

THE TREATMENT OF APOPLEXY.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Sept. 11, 1892.)

NOTWITHSTANDING the generally accepted views that but little can be done in the way of relief for a case of apoplexy, I believe that proper measures instituted promptly will do much to lighten the subsequent disabilities. Even preventive treatment is of considerable use, but unfortunately the lesions that predispose to cerebral hæmorrhage escape recognition so frequently, that but little is ever done for the patient in this respect.

It is pretty well recognized that apoplectic seizures can only occur in the presence of vascular degeneration. In all patients in whom this condition is likely to exist, all influences which serve to increase intra-arterial tension must be avoided. The most frequently observed pathological condition of the vessels producing apoplexy is miliary aneurisms. So far as we know, there is no known measure aside from such general ones as tend to maintain the normal standard of health, that will prevent their progress. Their rupture is only a question of time. Their diagnosis is entirely out of the question. Next to miliary aneurisms in frequency as a cause of intra-cerebral hæmorrhage is atheromatous changes of the bloodvessels. Here we depend upon the condition of the radial artery and the age of the patient as a means of diagnosis. This condition is likewise unpreventable, as it is one of the changes incident to advancing years. In young adults, practically the only cause of apoplexy is syphilitic degeneration of the arteries. This of course may be obviated by efficient treatment of the syphilitic diathesis.

Certain diseases of the kidneys act in a twofold manner to produce apoplexy. In the first place, they are not infrequently productive of vascular disease, and in the second, they are often associated with high arterial tension. Their proper treatment is practically one which lessens the chances of subsequent cerebral hæmorrhage.

Abstinence from meat diet and all alcoholic beverages, moderate indulgence in eating, a quiet life, the free drinking of water, the avoidance of exciting emotions, and the use of remedies like *glonoin*, *arsenic*, *arsenic iod.*, *phosphorus*, *belladonna*, and *nux vomica* are simply invaluable.

The treatment of the seizure itself is usually not very satisfactory,

in that some permanent damage nearly always results, and yet I am satisfied that much may be done to alleviate the symptoms and render these later phenomena of apoplexy less disabling. In the first place absolute rest is of the highest importance. It has been claimed by some authorities that the apoplectic attack coming on very suddenly, that all damage is done in an instant. This is a mistake. One not infrequently meets with cases in which the symptoms are an hour or two, and even longer in developing. Often under these circumstances patients are encouraged by their friends to walk around, to throw their bad feelings off; most pernicious advice truly. The rest should be so absolute as to avoid even the making of passive movements.

Attention to the posture with the patient recumbent is not to be neglected. When stertor is a prominent symptom, the patient should be placed on his side. The effect of this change is sometimes wonderful. The loud snoring respiration ceases, the congested face pales, and the arterial tension diminishes at once.

The clothing should be loosened, and the head should be so placed as to avoid flexion of the neck, thus doing away with all obstruction to the return flow of blood from the brain.

When collapse is not present, the application of ice to the head has a beneficial effect, as it serves to excite contraction of the cerebral vessels. When collapse is present, mustard plasters to the nape of the neck have been recommended by Gowers as of value in inducing reflex contraction of the arteries.

The lancet as a means of reducing arterial tension has been very properly abandoned by all intelligent physicians in the treatment of apoplexy. We may, however, employ the device first formally suggested by Dr. Dawbarn, of New York, to "bleed the patient into his veins," so to speak. As soon as possible the physician should cut off the return circulation from the lower extremities. This is done by the application of an Esmarch bandage, a tourniquet, or Spanish windlass to one or more of the extremities, and as near the trunk as possible. The apparatus should be made sufficiently tight to obstruct the return flow through the veins pretty thoroughly, but not so much so as to interfere with the arterial flow. Experimental evidence shows pretty clearly that this procedure lowers arterial tension, and favors the cessation of internal hæmorrhages. The pressure should be kept up for about an hour. Then the blood should be permitted to enter the general circulation very slowly. The only objection to Dawbarn's suggestion is that of possible danger in the

hands of those who are unskilled and who lack judgment. Persons of that kind should never undertake the treatment of a human being, no matter how mild his ills; consequently the objection fails to have weight.

There are cases, many of them indeed, in which all our best-directed efforts fail of relief, and deep and long-lasting coma supervenes. These must be treated on general principles. The bedding requires the most careful attention, owing to the danger from bed-sores; in extreme cases the water-bed is advisable, if not absolutely necessary. Extreme cleanliness must be enjoined.

When the extremities are cold, hot water bottles should be used. They should be applied with the greatest care, however. Owing to the patient's helpless condition the liability to produce burns is great, and a burn in a hemiplegic patient is a serious matter, for local nutrition is poor and the danger of sloughing correspondingly great.

In all cases stimulation by alcohol is bad practice.

Should there be a very high temperature (105° F. or higher) I should certainly have recourse to the ice pack. I have used it in other brain affections with high temperature with excellent results, though as yet not in apoplexy.

As to medicines, if in the beginning there is an excited condition of the circulation, *aconite* should be administered. It will almost certainly have a beneficial effect.

If the cerebral congestion be a prominent symptom *belladonna* should be thought of, especially with the characteristic circulatory disturbances of that remedy.

Glonoïn I would advise in cases in which the arterial tension is high and there is coexisting kidney disease. One drop of the first centesimal dilution should be given three times daily. As the administration of the drug is continued it may be given at shorter intervals until the patient is taking it every two or three hours.

Opium should be thought of in cases characterized by marked venous congestion. The profoundness of the stupor is not an indication for the drug, because that is dependent upon the severity of the case and therefore upon mechanical causes only. For this opium, or in fact any other drug, is powerless.

Arnica is the drug that should be administered after the acute symptoms have subsided to promote absorption of the effused blood.

For the subsequent paralysis *causticum* has done more good in my hands than any other remedy. It is of course impossible to say how much of the improvement in these cases is due to drug and how

much to time, which is certainly an essential element in their cure and improvement.

Sulphur and *baryta carb.*, the latter especially in old people, have likewise been recommended as remedies that will promote the absorption of the clot.

Attention to the kidneys is always an important matter. Whenever there is any albuminuria or excess of uric acid I advise the use of Londonderry or Buffalo lithia water, preferably the former carbonated.

When the subject of cerebral surgery was first broached it was thought that a possible remedy for apoplectic extravasations had been announced. Unfortunately, this is not so, for it takes but a little thought to see at once that surgical interference in the vast majority of cases is worse than useless, probably harmful. When the symptoms are such as to point without question to a sub- or extra-dural hæmorrhage, much may be accomplished, providing, of course, that the cerebral arteries are not too far advanced in their degeneration. When, on the other hand, the hæmorrhage is in the corpora striata, the effused blood cannot be liberated without seriously damaging important brain fibres.

Electricity is often proposed as a remedy in apoplectic paralysis. There is great danger that the pressure brought to bear by the family may lead to its use either too early in the case or in entirely unsuitable cases. I would advise that the patient be permitted to enjoy rest without electrical interference. In the course of a month or so the application of galvanism to the head may prove useful by promoting absorption of the clot. Galvanization of the contracted muscles and faradism of their opponents have been recommended when the stage of late rigidity has come on. I have had very little success with these measures, and have ceased encouraging patients to resort to them. I have decidedly more confidence in the applications to the head.

Horsley has recommended ligation of the common carotid on the side of the lesion as a means of stopping the internal hæmorrhage. There can be no doubt, if we are to judge from experimental evidence, of the efficacy of this procedure, but the operation is of such a severe character, and requires so many precautions to render it safe, that by the time it has been performed the hæmorrhage has ceased spontaneously. Carotid compression is probably as efficient.

Something can be done in the late stages of post-apoplectic paralysis by properly directed gymnastics of the paralyzed parts. The

aim should be to call the healthy side of the brain into play to help the injured one. This may be done by directing similar movements to be performed on both sides of the body simultaneously. It is astonishing how much better are the movements of the paralyzed extremity when thus performed than when the limb is made to move by itself. This is a field that has not been thoroughly developed, but I think it one of some promise.

The apoplectic patient is in every instance a disabled one. Though he should be so fortunate as to recover without a semblance of paralysis he is still largely incapacitated for his former labors. Ever afterwards he should live, as far as possible, quietly and abstemiously, enjoying life as best he may.

RETRO-BULBAR OPTIC NEURITIS.

BY CHAS. M. THOMAS, M.D., PHILADELPHIA.

OF the cases of impairment of vision and blindness met with in practice those occurring with *no causative change in the anterior part of the ball* are necessarily the least understood by the general practitioner, owing to his lack of familiarity with the use of the ophthalmoscope, but realizing his incompetency in this direction he, as a rule, earlier or later refers such cases without further thought to the care of a specialist. The class of cases, however, to which I desire briefly to call your attention here, and the discussion of which has heretofore been less general than it deserves, presents such distinctive features in its peculiar central impairment of the visual field, its frequent association with excessive use of tobacco, alcohol, etc., that its detection should not, as a rule, require the services of an expert. In fact, inasmuch as the ophthalmoscopic changes are usually absent or insignificant, one must, perforce, depend in the diagnosis of this affection almost entirely upon the character of the visual disturbance. Although long recognized as one of the distinct though rarer forms of blindness, and designated by Arlt as *retinitis nyctalopia*, it was not until 1880 that anatomical investigators in Germany and England proved that the real cause of the visual disturbance lay in an interstitial inflammation of the optic nerve posterior to the eyeball, and usually within the orbital portion. This neuritis is especially peculiar in that usually the inflammation in-

volves the fibres lying at or near the axis of the nerve, hence those which supply the macular region of the retina, this explaining the dark spot, or scotoma, so commonly found in the centre of the field of vision in these cases. The head of the nerve, or papilla, as seen with the ophthalmoscope, usually presents little or no change, though at times there is found a perceptible pallor of the inner lower quadrant.

At times, in the later stages of connective tissue development, a shrinkage sets in, which, gradually involving the more outlying fibres, leads to total atrophy and complete blindness. A few cases have been reported where isolated bundles of fibres escaping destruction, leave, in a general blind field, small spots or areas of fair vision.

The disease appears in both the acute and chronic forms. In the former an impairment or sudden total loss of vision (perhaps within a few hours) may be ushered in with, or preceded by, general headache and pain and soreness of the balls aggravated by pressure and motion. The visual impairment is either central, or, in exceptional cases, may be absolute and involve the whole field. Where it is confined to the centre alone it is not always complete at first, but simply indicated by an inability to distinguish colors (especially red and green) within this area, and on this account the affection is often not detected until it has passed into one of absolute central blindness.

In the chronic variety pain in the head, or soreness of the balls, is rarely complained of, the disease manifesting itself simply in the gradual, sometimes almost imperceptibly, progressive diminution of the sight; though in many, if not most cases, there is a marked aggravation in the disturbance during the day, or in bright light, accompanied by a sense of dazzling. In all these cases there is an inability to distinguish colors within the central portion of the field, and almost invariably, unless the case have gone on to general atrophy of the nerve, the periphery of the field will be found normal.

The ophthalmoscopic appearance in the earlier stages of both forms is usually negative, but in the latter the temporal half or the whole of the disc may be found abnormally pale.

As a rule both eyes are involved, and the impairment of vision, though lasting weeks or months, will in a fair proportion of cases result in a restoration of useful sight; in others a lost central area will persist either for form or color, or, finally, in spite of every care, complete blindness may result, hence the necessity for a guarded prognosis.

Where one is led to suspect the presence of this affection, the

simplest way to test the visional competency in the central portions of the field is to hold, as suggested by Knapp, a small piece of colored paper (red or green) not more than 3 mm. long with a pair of forceps in the visual line, while you look at the patient's eye, and let him look at yours. He will either be unable to see the color or will confound it with another.

With reference to the cause it may be said that a large majority of the *chronic* cases are the result of the excessive use of tobacco and alcohol, although poisoning by stramonium, chloral, lead and opium is said to produce a similar, if not identical, condition. While the acute form sometimes appears without apparent cause, it has been known to be developed through exhaustive physical or mental exertion, exposure, suppression of menses and during the progress of measles and diphtheria.

As to the treatment, the interdiction of tobacco and alcohol is of course an absolute essential. The eyes are to be put at rest, and protected from glare by suitably tinted glasses. In the early stages free sweatings and the Turkish bath appear useful; the old school favor free diaphoresis by pilocarpine; many favorable results have apparently followed the use of material doses of kali jodatum, and in the late atrophic stages from the use of strychnine. Homœopathically the selection of the remedy may be influenced much by concomitant symptoms and conditions. The most useful would appear to be, in the earlier stages, aconite, gelsemium, stramonium, opium, and in the later, nux vomica, iodine, phosphorus and sulphur.

The following two cases will serve as illustrations of the two forms of this affection.

Miss S., aged 28 years, had always suffered from irregular menstruation, the flow being irregular, scanty, and painful. A neurasthenic; had never complained of her eyes. After a prolonged exposure to a hot sun on a boating party just preceding her expected menstruation, she was seized with pains in the head and repeated short attacks of unconsciousness, which were at first supposed to be hysterical. The following day complained of dimness of vision, which rapidly increased, so that two days after she was entirely blind. Examination proved negative, with the exception of a rather dilated, sluggish iris and possible distension of the retinal veins. Blindness continued for the next two days, during which the headache persisted, accompanied by menstrual pains. Gelsemium was administered during this time. On the third day the menstrual flow appeared, but it was not until the evening of that day that vision

began to return, and then only in the periphery of the field, and as simple light perception. Improvement continued gradually, and at the end of six weeks a fair vision had been re-established, with the exception of a central scotoma, almost absolute, and general impaired color sense. The optic nerve appeared abnormally pale in its temporal side. At the end of another month the central vision was almost entirely restored excepting for appreciation of colors. Three years after, an examination showed the patient still color blind, but with useful vision in all portions of the field. The remedies employed after the first few days were mainly kali hydriodicum in material doses, fifteen to thirty grains, and sulphur 3x.

Mr. —, middle aged, sent me by Dr. Buchman, had for several months noticed a gradually increased dimness of vision at all distances, which had lately progressed rapidly after an attack of the grippe, so that at his first visit he had some difficulty in going about alone, and could not make out the largest type. Examination showed no perceptible ocular change excepting slight paleness of optic discs. While the whole field of both eyes was much clouded ($\frac{20}{200}$), vision at the centre of each was almost a blank. No color test was made. He acknowledged to having been a heavy drinker and smoker for a long time. Under nux vomica and kali jodatum and the regulation of his habits, vision gradually improved until, two months later, central vision was found to be $\frac{20}{200}$ in each eye, with a marked clearing of the periphery. Color test at that time showed most marked impairment of the color sense, specially for red and green. Two months later the central scotomata had almost disappeared, with vision $\frac{20}{30}$ full, and decided increase in ability to distinguish colors. At the last examination, in July of this year, the field of vision was found to be entirely clear, sight normal, and color sense quite accurate.

THE DEVELOPMENT AND REGENERATION OF THE DECIDUA.—G. KLEIN.—Decidual cells are found independently of pregnancy, as in membranous dysmenorrhœa, so that its presence is not proof of the diagnosis of pregnancy. If, however, there are both decidual cells and flattened, cubical or flat epithelial cells in a single layer in the utricular glands, the diagnosis of pregnancy is almost certainly correct. An absolutely sure microscopic sign of pregnancy has not yet been found, unless the presence of fetal structures, such as the villi of the chorion, are found. The epithelial cells are not flattened as the result of pressure or passive expansion, but by swelling of the protoplasm and nucleus of the cell depending on altered nutrition and vitality of the cell. Toward the end of normal pregnancy the decidua undergoes, to a great extent, coagulation, necrosis, and of slight extent, fatty degeneration; in either case the ovum becomes a foreign body, excites labor and is expelled.—*Centralblatt für Gynäkologie*, No. 33, 1892.

SOME POINTS BEARING UPON THE PROGNOSIS AND TREATMENT OF
VALVULAR HEART DISEASE.

BY WILLIAM W. VAN BAUN, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,
September 14, 1892.)

WHAT is the relative prognosis of the several anatomical lesions of the cardiac valvular apparatus, conditions or circumstances being equal? is a question constantly confronting us in considering the most frequent and most important diseases of the heart. While the question is difficult to estimate, we naturally turn to the valves of the left side of the heart as those in which our interest is chiefly centred. All authorities practically admit that *aortic regurgitation* is the most dangerous condition, the shortest in duration, the least responsive to remedial assistance and the most liable to sudden death. Still, the prognosis in this lesion, like in all others, is essentially one of efficient compensation, and as long as we find an apex beat in normal position, with regular rhythm, the outcome of the aortic lesion need not be a source of worry. This holds good in all valvular lesions, no matter where located. It has been stated and verified time and again that a cardiac valvular murmur, of itself, has but little prognostic value. The ratio this aortic condition bears to other valve diseases is variously estimated from 30 to 50 per cent. Halting a minute to review the causes of an insufficient aortic valve, we must admit congenital malformations, such as segment fusion, to be an important factor. It seems evident that a fusion of two segments of an aortic valve is stimulating to a condition of sclerotic endocarditis. Acute endocarditis of simple rheumatic origin, or that attendant upon or associated with specific fevers, plays a much milder part with the aortic valves than with the mitral; the storm passes by, leaving the aortic segments in perfect coaptation on closure—in fact, it seems to never produce aortic incompetency unless it passes to the stage of ulceration and destruction, in which case a rapidly fatal termination is the usual result.

The most frequent cause of insufficiency at the aortic orifice is an insidious, slowly progressive sclerosis of a valve segment, resulting in a turning or curling upon itself of the thin free margin of the valve, classed usually as a result of acute endocarditis, but is found in many cases in strong, robust individuals without a trace of rheumatic history or of any of the special febrile conditions having endocarditis as an accompaniment. In these cases *strain* will be found

to be the important factor—that is, a persistent, long-continued strain brought about by the heavy and prolonged use of muscles to the degree of excess, producing an abnormal tension on the valve segment during the period of the diastole of the ventricle—the condition in laborers, athletes and women in labor. Much has been written of late upon pregnancy and parturition as disturbing factors in the prognosis of valvular heart disease. In most instances I conceive the estimated importance of these two factors to be overrated, excepting possibly in the condition of aortic insufficiency or mitral stenosis or in combined lesions.

A recent case coming under my care impressed me greatly with the necessity of carefully weighing the best method of handling the second stage of labor complicated with this lesion either alone or in combination. A primipara of 33 years had been permitted to continue with vigorous but ineffectual labor pains for eight hours. When seen the pains were agonizing, with three- to five-minute intervals of rest, the patient's head and neck being swollen and cyanotic. This condition having existed for at least four hours, a rapid instrumental delivery, without anæsthesia, was accomplished, with apparent relief, the convalescence for ten days being all that could be expected. On getting up there was an immediate oncome of symptoms of ruptured compensation, resulting in death at ten weeks from date of confinement. Her history gave acute inflammatory rheumatic attacks at 12 and 20 years of age, with a resulting combined mitral and aortic lesion fully compensated for for at least thirteen years, and which was evidently broken by the continued eight-hour strain in the travail of labor.

Alcohol as a producing cause of aortic insufficiency is a good second to strain. The history of these cases usually shows a stereotyped recurrence of the combination of strain and alcohol, with syphilis thrown in to vary the monotony. The condition of sclerotic valve change is often associated with atheroma, either fatty or calcareous, or with an endarteritis extending to the valves. If the diagnosis of either of these conditions can be established, the prognosis will be relatively of a more serious character. Aortic insufficiency due to traumatic segment rupturing is rare, especially in healthy subjects, although it may occur in cases of sudden excessive strain, as in the case of a miller under my notice, aged 44, apparently perfectly well, who was fixing some mill-stones. With assistance he turned one up on edge. Suddenly he noticed it was falling towards him, when he made what he termed the effort of his life, throwing himself against the stone and

overbalancing it to the other side. It seemed to him as if something had given away in his chest, and he immediately felt sick and dizzy. He was assisted home, and when seen presented all the signs of aortic insufficiency. He recovered to the degree of being able to move around slowly, with a well-established murmur, but has never been able to perform any manual labor. It is now more than three years since the date of the accident.

Aortic insufficiency due to a relative dilatation of the aortic ring is rare, exceedingly so, although the natural tendency, from the fortieth year upward, is for the aortic ring to gradually increase in size, dilating frequently nearly 20 per cent. This physiological tendency at the period of life when the valve is most apt to be affected with sclerotic changes must not be overlooked.

The direct effect of aortic insufficiency is a regurgitation of blood from the aorta into the left ventricle during the period of the short interval of rest and the diastole. This causes an over-distension of the ventricle, with a subsequent dilatation and hypertrophy. It is in this lesion that dilatation and hypertrophy reach the greatest limit. The prognosis is largely dependent upon the condition of the coronary artery.

While we admit that aortic insufficiency is the most serious of all valvular troubles, and the one most apt to be associated with sudden death, we must remember that in a simple, uncomplicated case of aortic insufficiency which is fully compensated for by a condition of hypertrophy just sufficient to equalize the valvular defect, the patient may suffer no inconvenience and be able to pass a fairly active life for years. I have had a case under my personal observation for ten years, with a well-established aortic failure, who passed through a slight rheumatic seizure three years ago, at the age of 56, and who is now enjoying a fairly active life, with no unusual symptoms, excepting short attacks of palpitation two or three times annually. Cases of this kind may exist for years, and only be accidentally discovered when searching for other conditions. With the onset of a mitral insufficiency there is a tendency to a rapid myocardial change, etc., and a rupture of compensation, the prognosis becoming uniformly unfavorable. If the insufficiency be associated with attacks of severe angina pectoris—a condition found with this valve lesion more than any other—the patient's friends should be warned of the impending danger of a sudden death.

The abrupt ending of life in cases of aortic regurgitation is usually due to either acute dilatation or to blocking of branches of the

coronary arteries. It will be remembered that children, as a rule, are not subject to sudden death.

AORTIC STENOSIS.

In comparison with aortic insufficiency, a stenotic condition at this valve is very rare. In almost every case of stenosis there is some regurgitation or leakage, whereas regurgitation frequently exists without stenosis. It is usually met with in old men whose arterial system has undergone or is undergoing extensive calcareous change. In almost all cases it is associated with a dilated left ventricle, giving rise to a moderately enlarged cavity, or no increase at all, with a very much thickened muscular wall, provided, compensation is maintained; if not, then the usual changes rapidly ensue. Aortic obstruction is usually held to be the least serious of all the valvular lesions. It is a rare condition and is usually well compensated. In many instances it seems to have no influence upon the duration of life. We must bear in mind that there is a vast difference in the same physical condition when the result of different causes. For instance, an aortic lesion due to or caused by a rheumatic fever in a young person otherwise healthy requires a very different interpretation from the mechanical condition occurring as the result of chronic atheromatous arteritis with extensive degeneration of the arteries. In this latter case, even though the aortic stenosis may produce but slight symptoms, the friends of the patient must be informed that there may be a sudden and fatal syncope.

MITRAL INSUFFICIENCY.

Of all chronic valvular heart lesions, an uncomplicated primary mitral regurgitation is probably the least liable to the danger of sudden death, but it is the condition that is most speedily followed by pulmonary obstruction, venous engorgement and general anasarca; in other words, the water-logged state, or being drowned in one's own fluid. On general principles, the prognosis of mitral insufficiency is much more favorable than the same condition at the aortic valve, and it is less favorable than aortic stenosis. The murmur of mitral insufficiency may be very pronounced in a recumbent position and totally absent in the erect, a condition that is apt to be misleading. The three classical features of mitral regurgitation: a systolic murmur of greatest intensity at the apex, transmitted to the axilla or to the lower angle of the left shoulder-blade; accentuation of the pulmonary second sound, and enlargement of heart transversely will usually establish the existence of this lesion. But we may find

a well pronounced systolic murmur of maximum intensity at the apex, which is transmitted to the axilla, which is not associated with mitral incompetency, and which is known as an accidental murmur of unknown cause. With this lesion well marked, the prognosis for pregnant women is good, yet there is a liability to cardiac accidents during labor dependent upon the severe, long continued strain. The prognosis will be governed by the resisting or staying power of the patient.

It is claimed that in reality no valve lesion is so speedily fatal and so poorly compensated as that in which the mitral segments are curled upon themselves, puckering and forming a narrow rim around the wide-open mitral ring, a condition not infrequently found in children. In other cases, so great is the compensating ability of the heart's reserve that cases have been reported of unbroken compensation, lasting from thirty to forty years or more, with little or no distress, even in cases where hypertrophy has been well marked. The condition of mitral insufficiency is amenable to treatment, the results being usually satisfactory.

MITRAL STENOSIS.

Mitral stenosis in adults is more frequent than incompetency. These cases go on for a long period, and the prognosis is better than in mitral regurgitation, but the possibility of a recurrent endocarditis, with the probable tearing away of vegetations, which may fall into the blood current and be swept along the arterial highways until they block some smaller vessels like a cerebral artery and cause hæmiplegia or aphasia, or both, must be borne in mind, as well as the likelihood of life being cut short by sudden death in like manner. In such a case the prognosis of stenosis is, of course, more unfavorable than regurgitation. Stenosis of the mitral, in many cases, is thoroughly compensated for with hypertrophy, and is maintained many years. Failure of compensation brings the usual train of symptoms dependent upon general cardiac degeneration, although the great majority of stenotic cases do not have dropsy. Mitral stenosis is by far the most dangerous cardiac lesion to pregnant and parturient women, and yet they may pass through repeated pregnancies with safety. Where this condition exists, marriage should be interdicted.

Whatever the lesion and wherever found, hypertrophy, as a rule, is desirable, while dilatation without hypertrophy, excepting to a small amount, is serious, and is to be viewed with regret as an element of danger. The best condition possible is the presence of

a murmur with no physical signs of dilatation or hypertrophy, and with symptoms noted for their absence rather than presence, such as pallor, dizziness, dyspnoea, palpitation and other cardiac indications.

The combination of valvular lesions as an element in prognosis is without much value excepting in the extent. Aortic regurgitation is not materially affected by the presence of a mitral regurgitation. But when mitral regurgitation is complicated with a stenotic condition, it is far less amenable to treatment, and mitral stenosis takes on a new character and additional symptoms when regurgitation is present. A combined lesion in a pregnant woman is to be received with alarm. The result to the woman will probably be fatal, and the question of the forcible removal of the product of conception must be thoroughly weighed, the woman being given the benefit of a doubt.

The prognosis of all valvular conditions of the heart, on the whole, is better for women than for men, owing to the fact that woman's work is easier and life is more tranquil. This is particularly noticeable in mitral stenosis, to which they are more liable than men, and it is astonishing how they will revive from conditions that are apparently beyond hope. The great secret of success in these cases is to get the patient to adopt the motto of "moderation in all things," and to live faithfully to the idea. Hard work, exposure, dissipation, starvation, drink, exercise to fatigue, and excess of any kind are all disastrous to otherwise favorable cases.

All valvular diseases are of less importance than those of the cavities themselves, for dilatation, fatty or fibroid change of the walls of the cavities give rise to the most serious cardiac symptoms, and often result in sudden death.

TREATMENT—DIETETIC AND HYGIENIC.

The diet in all cases should be wholesome, easily digestible, and non-stimulating, tobacco and stimulants being rigidly prohibited. Exercise should be regulated by the patient's individual sense of fatigue, and will prove beneficial if there is no cardiac distress or palpitation. The action of the skin and bowels should be maintained, the former by baths in moderation, the latter by the indicated remedy. Turkish and Russian baths are to be avoided, as well as the ordinary hot bath. Coitus is not free from danger, especially in aortic insufficiency. High altitudes are to be avoided. To sum up under three cardinal conditions, mal-nutrition, mental worry, and over-exertion are a tripod of danger with death as a pendant centre.

EDITORIAL.

THE WORLD'S CONGRESS OF HOMŒOPATHIC PHYSICIANS AND SURGEONS.

THE skillful and far-seeing executive ability of Dr. J. S. Mitchell and his committee having in charge the arrangements of a congress of homœopathic physicians and surgeons to be held in Chicago in May, 1893, has led to the formulating of a programme for scientific and general work that apparently is devoid of error, and which promises a great and lasting triumph, the success of which will be far-reaching and of great benefit to homœopathy. With wisdom that reflects credit upon both chairman and committee the error of the Atlantic City congress has been avoided, bureau or sectional work has been justly recognized and placed upon a firm basis; the evident care displayed in the selection of the sectional chairmen is in itself a safe assurance that the scientific standard of this congress will be exceptionally high. Provision has been made for nine sections, practically embracing the entire field of medicine and surgery and the collateral branches; each section is allowed eight essayists. These undoubtedly will be selected for their especial proficiency in the branch of medicine or surgery under cover of the section. Adequate time will be allowed to properly present and read the essays and papers, and the discussions will be well taken care of by the appointment of two debaters for each essay who will previously be furnished with an abstract of the article they are to discuss. After which all who desire to speak upon the subject will be afforded an ample opportunity. It would be hard to improve upon this arrangement, and all who are deeply interested in scientific medicine can put aside all feelings of doubt and go to Chicago with full confidence that they will return with absolute satisfaction from every standpoint. In addition to this excellent provision for bureau or sectional work there will be at least eleven addresses by distinguished foreign and American members of our school upon subjects of general interest, such as "The Homœopathic School and Public Health;" "Historical Development of Homœopathy in Germany;" "The Further Improvement of Our Materia Medica;" "Homœopathy and Prophylaxis;" "The Value of Specialties in Medicine;" "Bacteriology;" "The Value of Efforts to Enlighten the Public on Hom-

œopathy ;" "The Relation of Adjuvants to Therapeutics ;" "Medical Education in the Homœopathic Colleges and Hospitals of the United States ;" "The Future of Homœopathy ;" "The Selection of the Homœopathic Remedy ;" "The Development of Medical Science Through Homœopathy," etc. The vast scope outlined gives food for thought and interest for all and any physician who by commencing to make arrangements early can attend this congress owes it as a duty to himself and his patients, who repose in him their health and lives, to go and derive all the vast personal benefit each and every one can obtain by being in close contact with the largest representative medical gathering that America will know for years to come.

Chicago will offer in 1893 every attraction to induce one to prolong their stay, and wherever possible this inclination to remain should be indulged. Doctors as well as others can develop their artistic and mechanical tastes to advantage. What an opportunity there will be to study the development of the artistic and the beautiful in America since 1876? Who cannot recall the great big commercial exhibition of the Centennial revealing the stupendous material wealth of our country and the ruthless awakening to the fact that we were sadly deficient in the artistic? Who that looked upon the impressive *ensemble* of the Paris exhibition of 1889 and realized the artistic triumph of its architectural, sculptural and natural features but has had a fear—a fear for the artistic at Chicago? But who that has watched the magnificent and unrivalled achievement of Chicago has doubt now that we are not more than the rival of the most artistic nation of the world? If you have doubt go see for yourself, and you will never regret having seen the most wonderfully interesting and beautiful spectacle of the age.

THE DISPENSARY QUESTION.

THE dispensary question is still a live issue, though an old one. The truth of this was exemplified most strikingly at a recent meeting of the Philadelphia County Homœopathic Medical Society, when the Committee on Essays and Debates announced a discussion of a resolution as follows: "*Resolved*, That free dispensaries as at present conducted, are mistaken charities—an abuse to the profession, and a moral evil in the community, as they promote dependence

and foster pauperism." The attendance brought out to listen to the debate was one of the largest in the society's history. Dr. G. Maxwell Christine presented an argument in favor of the affirmative, while Dr. C. S. Schwenk maintained the negative. These papers appeared in full in our report of the county society meeting in our last issue.*

There is undoubtedly an abuse of medical charities. We should not for that reason take the affirmative side of the resolution, and present a sweeping condemnation of dispensaries and hospitals.

It is needless to say that the "well-to-do" very, very, rarely patronize dispensaries. When they do so, it is usually with what appears to their minds to be an all sufficient reason. Lack of tact on the part of a practitioner leads to lack of candor on the part of the patient, who feels that possibly in the course of a tedious illness there is much that has been concealed from him by his medical adviser. He therefore seeks, as he is pleased to express it, the fountain of learning, where he will have his case commented on by "the professors" before their students. In adopting this trick, he doubtless thinks himself shrewd, but it is only because he has managed to get by trickery what he wanted, a candid opinion. He would be horrified if any one had suggested that he had been guilty of "dead-beatism." We have seen people of this class contribute liberally to the hospital fund.

The chief patrons of the dispensaries are the working classes and the tramps. Concerning the former it is often said that many of them should not be permitted to receive medical aid, because they have paid physicians in the past, or still owe physicians, or that they have regular work, and therefore need no sympathy. As to tramps, they are such by their own vices and so deserve none.

We have always felt that the working classes do remarkably well in paying their way. We do not of course include among these those who spend nearly half of their earnings in rum and general dissipation. The majority of these will pay their medical bills regularly for years until a severe and long lasting illness plunges them hopelessly into debt, thus driving them to our medical charities for assistance. It may be the bread winner himself who is the subject of the illness, in which case, the income stops and expenses increase. They always paid before, why do they not do so now? we

* By an oversight in making up the authorship of these papers was not properly stated.

hear. They now go to the dispensary and save their money to pay their old doctor. Why should they not do so? There are very many people of just this class, and dispensary physicians have complained of them. They will take the ground that the patient when restored to a financial status enabling him to meet his obligations should then patronize those who befriended him in his hour of need. Say they, "the people use us to pay others."

Of the class who spend so much in dissipation, there can be no question of their requirements. They have no money for the doctor, and what is still worse, owing to their bad habits, they are in need of him very frequently. They must use the dispensary all the time. If they should perchance consult a practitioner, they succeed in avoiding payment of his bill. The bad effects of their evil ways are not confined to themselves; a wife and little ones, perhaps aged parents feel the strain. Medical charities here do noble work in relieving the distress of the innocent ones. The cause of all the evil reaps advantage also; but this cannot be helped. He is a sick human being without money, and the pity one must necessarily entertain for a suffering fellow-man prompts us to extend him a helping hand, unappreciative and ungrateful though the recipient prove to be.

Veneral cases are said to be undeserving of medical charity. They are not deserving from the moralist's standpoint. But they, likewise, are suffering mortals. A heart of stone gives forth sympathy to a suffering brute. These people are often of the lowest classes, without honor, or any semblance of decency. They have no money, and their dissolute ways will probably preclude all possibility of their ever having any. Shall we say that their patronage of the dispensary should not be permitted?

Families have been criticized because they permit their servants to seek aid of dispensaries and hospitals. It is hard to see how the latter class can make their small incomes (never more than two hundred per annum), pay all expenses, in addition to occasionally giving of assistance to relatives. Hospital managers criticize ladies for sending their servants to the hospital instead of caring for them at home. But look at this for a moment! Is not the instability of the maid-servant proverbial? Are not her migratory habits to our housewives what the tariff question is to our citizens? Have we any right to expect that our ladies shall nurse them, and pay their medical bills in addition?

Then there are store-girls, who are compelled to pay board and

dress well on two hundred and fifty dollars per annum. The majority of this class patronize physicians for awhile. They are young, their health is good, they have but little sickness, and the draught on their exchequer for medical services is very light. But the heavy work to which they are subject soon tells on them; they sicken, and are driven to the dispensaries for aid. Are they not entitled to it?

In the discussion following Drs. Christine's and Schwenk's papers, Dr. John E. James called attention to what is probably the greatest dispensary abuse, that of some practitioners (they are few in number, but frequent offenders) of sending patients to dispensaries for expert opinions when the latter are abundantly able to pay their regular advisers. Dispensary officers oftentimes know that these parties are not entitled to their charity, but are obliged to submit to the imposition to please a brother practitioner. Cases illustrative of the abuse have often been related. One physician, a member of the visiting staff of a large hospital, examined a patient at the request of her family physician. He did so at his office, and during a season when he was not on hospital duty. He rendered a bill, which was indignantly repudiated by the patient, who was backed up by her doctor, on the ground that the consultant was a hospital physician and should give his services free whenever required to do so. And still another instance: There recently appeared at one of our large hospitals two women and a child. All three were well clad, the women wearing seal-skin sacs and diamonds. One of them was the child's mother, the other his aunt. They had come three hundred and fifty miles for an opinion, and had been told by their physician that they might as well save themselves the expense of a consultation fee, as the consultant would give them as good an examination at the dispensary as he would at his office. They improved the opportunity afforded them by their visit to the city to remain two weeks and look around. Was there ever an abuse like this?

We are not unmindful that many people who are able to pay ordinary fees for general medical attention are unable to pay for expert opinions and operations requiring unusual skill and judgment. To them the hospital is a boon indeed, and they deserve to improve the advantages it affords them.

Such is the point of view of the dispensary question when large central charitable institutions are the subject of study.

But there are other medical charities, generally small ones, that

present not only all the abuses of the large ones, but still others, which are more outrageous. These provincial or local charities receive their patronage from the neighborhood in which they are situated. They, as a rule, work an injury to the local profession. The residents patronize them for their small ailments, and go to their physicians when they are seriously ill. Having recovered, they return to the dispensary, feeling no obligation whatever to reward their regular physician by paying his bill.

What may be said against these small affairs is ten thousand times true of "private" dispensaries. These latter are usually organized under the mistaken belief that they advertise the officer in charge. So they do, but unfavorably. People may patronize the cheap doctor-shop, but they do not respect its proprietor. Instead of the latter securing them as regular pay-patients when he sees fit to close his doors, he will only find that he has forfeited their respect.

Can anything be done to remedy the above-named abuses? We see no remedy but education, and this will surely do it. We know that dispensaries to-day are not abused to the extent they were ten years ago, when dispensary advantages were less than they are to-day. It is well-nigh impossible to discriminate against applicants for relief. Because a man is able to save a small sum from his monthly stipend is no excuse for turning a deaf ear to his application, for he must have something "laid by" for living expenses in case his income should perchance cease. We cannot name an arbitrary limit at which ability or inability can be correctly stated to exist. We cannot refuse an applicant because he has been wasteful, nor, again, because his sins have brought misfortune upon him.

Education of the people to respect of self and others, and of the rights of their private medical advisers, and a determination of the latter to do everything that will increase that respect, is the solution of the dispensary question.

THE CYCLOPÆDIA OF DRUG PATHOGENESY.

NORWITHSTANDING the remarkable success of the *Cyclopædia of Drug Pathogenesis* from a scientific standpoint, the American Institute of Homœopathy has been at considerable financial loss in backing

its publication. The undertaking of business enterprises by non-business associations is always apt to result unfavorably so far as finances are concerned. We feel that this work should be in the hands of every homœopathic physician, and are accordingly pleased to learn that the Institute while retaining its interest in the work, has shifted the business management of it on the broad shoulders of Otis Clapp & Sons, of Boston, Mass.

A DANGEROUS SIMILARITY OF NAMES.

Two quite dissimilar products are the unfortunate possessors of very similar names, euphorin and euphen. Mistaking the latter for the former might readily lead to a fatal result. Euphorin is phenylethyl urethane, carbonate of ethyl and phenyl, a white powder of slightly aromatic odor and taste; it is said to be antipyretic, anodyne and antiseptic; the dose is from seven and a half to fifteen grains. Euphen is said to contain 21.8 per cent. of iodine, and the dose is from one-quarter to one and a half grains. It is said to have antisiphilitic properties.

A NEW DEPARTURE.

It is reported that the Mississippi Valley Medical Association has swept away all codes, and altered its by-laws so as to now admit all reputable physicians of any school of medicine. This is a long step in the direction of medical liberty. The effect of the advance will be marked with interest. The deed will only bear fruit if backed by the honest opinions and sentiment of the best element of the association. If merely a campaign move done only for effect it will fall decidedly flat.

HOMŒOPATHIC physicians in every state of the Union should make it their duty this coming winter to see that their legislature makes adequate provision for the insane who may want homœopathic treatment.

GLEANINGS.

GENERAL MEDICINE.

CONDUCTED BY

WM. W. VAN BAUN, M.D.,

FRANK H. PRITCHARD, M.D., AND EDWARD M. GRAMM, M.D.

THE CHOLERA.—The entire *seance*, of September 20th, of the Academy of Medicine, of Paris, was devoted to the discussion of the cholera. The question had already been opened, during the last *seance*, by a communication by Professor Peter, in which he presented his ideas on the nature, contagiousness and treatment of the reigning epidemic. Two points are prominent in the communication of the writer, the unicity of the disease and its restricted contagiousness. He was in charge of a department for cholera patients at the Hôpital, and received, in all, 118 cases. Of these there must be excluded 10 cases of simple diarrhœa and enteritis, reducing the number to 108, and, as there were 44 deaths, the resultant mortality was 40.8 per cent. This rate is that of the cases taken all together, the cases of cholérine, bilious cholera and those with rice-water stools. But in the serous variety, with rice-water stools, the mortality was 66 per cent., 30 per cent. in the bilious stools and 0 per cent. in those with common diarrhœic discharges. From a bacteriological point of view it may be remarked that the comma bacillus was found in all the cases with rice-water stools. It was either alone or associated with the bacterium coli. In these cases the physician is nearly powerless, and it must be frankly avowed. In a large measure the mortality followed the fluctuations of the atmosphere, increasing with the heat and decreasing with the cold. From the 22d to the 30th of August, with a cool temperature, the mortality was 16 out of 27 patients. On the 1st of September the temperature rose, and 6 out of 7 perished. This fact may be supported by numerous examples, and it is an argument in support of the theory that the disease depends upon the medium in which we live. Although the atmosphere is the great medium, it is not the only one, for filth, bad ventilation, etc., have their influence. Contra-distinguished to these are influences at work in the system of the patient, as senility, debility from excess, poverty, insufficient nourishment and unwholesome drinking-water. The water of the Seine, in fact, differs but little from that of the Ganges, where the cholera is always present. The influence of these latter is incontestable, and if the epidemics of to-day are not so severe as those of ancient times, it is due to their being controlled by better hygienic measures. The writer has seen the Paris of 1832, 1849, 1865, 1884, and he can say, with certainty, that the Paris of 1892 is much changed; indeed, it does not resemble the same city of yore. Large avenues of communication and better means of ventilation have greatly altered the atmosphere in which the inhabitants live. It is to this that the benignity of the recent epidemics is to be attributed. As to the nature of the disease, he does not believe that there are several kinds of cholera any more than there are several kinds of scarlatina or measles. There is a light form of cholera, or cholérine, a graver form or cholera nostras, and a still graver form, with rice-water stools, which is wrongly called Asiatic cholera. This latter form, beyond its special gravity, only differs from the preceding forms in the greater intensity of the inflammatory process, with accompanying exaggerated secretion and pronounced epithelial desquamation, giving to the stools the rice-water appearance so well known. It is not a question of special diseases here any more than one would regard the various forms of scarlatina or typhoid fever as special diseases. With regard to the bacteriology of the disease, 35 cases were studied, from beginning to end, bacteriologically. Of these there were 4 cases with ordinary diarrhœic dejections, 6 with bilious passages, 14 with mixed stools of a bilious and rice-water consistency, 6 with pure rice-water stools, 6 dysenteric, and 3 where the dejections were not examined. The examination resulted in finding the bacillus virgula in 3 cases; 9 with the bacillus bacterium coli; 1 case with a bacillus resembling the bacillus virgula, recorded by Finkler-Prior as the cause of cholera nostras; 4 cases with the bacillus virgula and the bacterium coli mixed; 6 cases with

the bacterium coli associated with the bacillus virgula of Finkler-Prior; 1 case with a diplococcus; and 11 cases where the examination was not complete. Experimentally the bacillus virgula was not cultivated. The bacterium coli showed itself to be very virulent, killing a rabbit at the end of fifteen to fifty-two hours, with symptoms of experimental cholera. Diarrhœic stools, with retention of urine, elevated temperature, set in one to two hours after inoculation and continued until death. Paralysis was present in 2 cases. At the necropsy an intense congestion of the intestines, marked swelling of the follicles and Peyer's plaques, with epithelial desquamation of the intestinal mucous membrane, were found. With regard to the contagiousness of the disease, the writer asserts that there is an absolute and a relative contagiousness. Absolute contagiousness concerns those diseases where the microbe is not known, as in scarlatina, small-pox and measles. Relative contagiousness is that of the affections where the micro-organism is known, or thought to be known. Given in their decreasing degree of contagiousness they are: diphtheria, typhoid fever and cholera. The writer claims that cholera is but little contagious, for the fear of the microbe is by no means the "beginning of wisdom," but rather the beginning of insanity, even savagery, not only in the demi-civilized countries, as Persia and eastern Russia, but also in civilized countries, as the New World. Behold New York arrayed against Europe, and Portugal against New York, which is perfectly logical if one believe in the microbe. As to treatment, the writer combats the initial diarrhœa by means of the opium preparations, annihilates the central reflexes of the solar plexus by application of an ice-bag to the spine. This application causes the cramps to disappear nearly completely or to become relieved greatly. The coldness and collapse are combated by frictions, injections of ether, caffeine, and especially by mustard baths, which cause the temperature to rise for several hours. In the meantime, one must keep up the strength by alcoholic drinks, champagne, etc.

Professor Brouardel commenced by taking up the idea of the innocuity of the cholera emphasized by Professor Peter. He cannot see how the professor, admitting that there are two kinds of microbes, can think that two kinds can produce the same product. Then, again, there is a great difference between the cholera of India and that of the suburbs of Paris in its course and propagation. The cholera of Hamburg has already been disseminated in the adjacent countries, while that of Havre has remained isolated at the point of original outbreak. He does not regard the cholera in France as the Asiatic cholera. The clinical symptoms cannot be our guide, for they are not identical in all varieties of cholera, and they easily may be confused with arsenic poisoning or that of antimony. Hence bacteriology remains, but it is not proven that Koch's bacillus is the invariable characteristic of Asiatic cholera. Cholera has been produced by the bacillus of Finkler-Prior, and cholericiform symptoms have been produced by matters from privies, and only containing toxins without bacilli. Dr. Gabriel Pouchet has isolated from the dejections and vomit of cholera patients various ptomaines, which mere carrying about one's person is sufficient to produce the symptoms of cholera. Hence he does not think that one is to be permitted to throw the cases all together, and asserts that the disease is always identical in its nature. The cholera germ may be absorbed with its incommoding one, but if this same germ enters the system of individuals, weakened by misery, poverty and excesses, it produces the disease and death. Dr. Guibert has translated this thought by asserting that out of 10 cholera patients who have been addicted to alcoholics, 9 die, while out of 10 abstemious persons one will be able to save 8 or 9. He cannot see how cholera can arise in the interior of the system of the patient without the presence of germs. As to the contagiousness of the disease, he regards it greater than that of typhoid fever. Water is one of the principal means of its propagation, but not the only one. Propagation of the disease may be prevented, and if one cannot hope to prevent the spread of the disease at the frontiers of a country, one may isolate and disinfect the patients, thus diminishing the number of foci and rendering its extinction easy. The fear of the disease in France is not any greater than formerly, for the inhabitants of Havre had their families return who were away from home, and in Paris the hotels are all full of strangers. The means within our hands permit us to combat it successfully.

Although we differ with regard to various doctrinal points, we are all of one accord in regard to the prophylactic measures. Professor Peter added, in return, that the bacterium coli, ordinarily inoffensive in the normal state, may, under certain determined conditions, acquire extreme virulence. It is found in the stools of

dysenteric patients, unassociated with any other micro-organisms even in the viscera, as the spleen, liver, etc. Drs. Rodet and Roux admit that this micro-organism may, in certain cases, undergo certain transformations as to acquire pathogenic properties, which, morphologically and biologically resemble greatly Eberth's bacillus, as ebertainform transformation, to use the expression of these two savants. What does this not prove if not that the soil does change the micro-organism in modifying its characteristics? In other conditions this same organism, which is exclusively in the stools of patients with cholera nostras, may, owing to the soil, undergo such modifications as to become identical with the bacillus of Finkler-Prior, or even resemble the bacillus virgula. Here it is no longer ebertainform but choleriform. He admits the modification of micro-organisms, and especially of this one, and again when one but recall the changes which geological species, as well as those of the vegetable and animal kingdoms undergo from their soil and surroundings, one may easily admit that these organisms, infinitely smaller, can become modified much more rapidly. Professor Verneuil believes rather in microbial association than of transformation. It is well known that the bacillus of Nicolaer is virulent when associated with the bacillus of malignant oedema, the bacillus of diphtheria when accompanied with a streptococcus greatly increases the gravity of the prognosis. These facts should not be forgotten.—*La Tribune Medicale*, No. 33, 1892.

NEW USES FOR SULPHONAL.—Apart from its use in simple insomnia and some of the neuroses, sulphonal appears to be of value in controlling such symptoms as reflex spasm and the uneasiness following injuries. Andrews, of Chicago, speaks of sulphonal as a certain remedy in the treatment of muscular cramps of the legs appearing during the night, and especially those accompanying fractures of the long bones. In a case of recently fractured femur, fifteen-grain doses gave immediate relief. In the after-treatment of laparotomy, Jonas says that the treatment of sleeplessness occurring in these cases could always be relieved, lest insomnia seriously interfere with recovery. He usually gives sulphonal in such conditions. Althaus recommends sulphonal for the insomnia that is apt to occur in the psychoses following influenza.—*N. Y. Medical Journal*, November 5, 1892.

GENERAL SURGERY.

CONDUCTED BY

WM. B. VAN LENNEP, A.M., M.D.

THE TREATMENT OF COMPOUND FRACTURES OF THE ARM, FOREARM, THIGH AND LEG BY MODERN METHODS.—Burrell and Dwight give the results of a study of 160 cases treated in the Boston City Hospital. There were three deaths, none being from sepsis (two from tetanus and one from fat embolism). Under the older methods the mortality ranged from 28 to 68 per cent. The following points should be considered:

1. *What cases can be saved with a useful limb and what cases require amputation?* This is decided (a) by the age of the patient, old age not necessarily indicating amputation, and his physical condition as regards alcoholism, renal trouble, etc. (b) By the condition of the soft parts, vessels, nerves and bones; obliteration of the main vessels calls for amputation, but extensive crushing and the consequent swelling may prevent the recognition of pulsation, hence the attempt should be made to save everything, resorting to secondary amputation if necessary. (c) By his environment, the attention he will receive and the facilities for "putting up" the limb antiseptically and in plaster-of-Paris.

2. *How to "Put up" a Compound Fracture.*—The strictest antiseptic precautions are observed and an anæsthetic used. Where there is simply a puncture of the skin the limb and wound are scrubbed and shaved, washed with ether and then with sublimate, and the fracture converted into a simple one by suture. When the wound is dirty or the bone protrudes, all cavities and pockets are laid open; completely detached pieces of bone are removed, unless very large or attached to the periosteum; devitalized tissues are cut off; the bones are replaced and the wound closed without drainage. The dressing is baked gauze, the inner layers being saturated with bichloride solution, and a light plaster of-Paris cast.

Where the fracture is so severe that amputation may be necessary, Bolles' or Bover's fracture box or Smith's anterior splint are used instead of the plaster.

Plaster-of-Paris bandages are made of crinoline, washed to remove the sizing, which hinders "setting." They are four or five inches wide and five yards long. The addition of salt to the water in which they are immersed will make the plaster brittle. Two bandages are sufficient for the leg, three or four being needed when they are carried up to the middle of the thigh. They are not reapplied after being cut.

3. *The Management of a Compound Fracture.*—The success of wound-healing depends on the care exercised in the first dressing. This is changed on the seventh day and again on the fifteenth, when union is beginning. It can then be reapplied to remain in place until the completion of bony union.—*Boston Medical and Surgical Journal*.

EMPHYEMA OPERATIONS.—Rosenbach considers incision and the introduction of two stiff drainage tubes sufficient in fresh cases. Rib resection is only necessary in old cases and must amount to a thoraco-plasty to close the rigid walls of the cavity.

In exploratory puncture pus cannot be drawn through the canula when it is thick and flakey. The canula must be withdrawn with the syringe exhausted. The piston is then pushed down, forcing any pus that may be fixed near the point of the canula on to an object glass. When this fails the exploration may be said to be negative.—*Deutsche Medicinische Wochenschrift*.

PREVENTION OF URETHRAL FEVER.—Bryson (St. Louis) after reviewing his genito-urinary work for sixteen years, recommends the following points as preventive of urethral fever.

1. The administration of a urinary antiseptic for a day or two before any manœuvre which might excite urethral fever. The upper and middle portions of the urinary passages are acted on more than the urethra. Boric acid is the best agent.

2. All instruments are rendered aseptic by boiling in soda solution.

3. Borated glycerine is alone used as a lubricant, fats, oils, and vaseline being discarded entirely. Glycerine can be removed from instruments on account of its affinity for water. On exposure to the air it becomes too thin for use, and when infected it becomes opaque. It increases the urethral secretion, which washes out the canal and promotes absorption.

4. Before any instrumentation, the foreskin is retracted and the parts thoroughly cleansed with Thiersch solution.

5. The anterior urethra is distended and washed with an ordinary bulbous injection-syringe.

6. An attempt is made with the same instrument to wash the posterior urethra by over-distension. Failing in this, an Ultzmann irrigation catheter is used.—*Journal of Cutaneous and Genito-Urinary Diseases*.

THE TREATMENT OF BURNS.—In Hahn's Clinic (Berlin) all recent cases of burns are treated as follows: The lesion is thoroughly cleansed, and irrigated with carbolic or salicylic acid solutions (sublimite causes too much pain). The entire burned area is then covered with finely-powdered subnitrate of bismuth; cotton is applied over this, the outer layers of which are removed when soiled. Owing to the waste of bismuth by insufflation, bandages of gauze are impregnated with bismuth and starch.—*Deutsche Medizinische Wochenschrift*.

CEREBRAL ABSCESS.—Ransom records a successful case: Old otitis media; rigor and delirium, with stupor, hemiplegia and facial palsy; optic neuritis; trephining of mastoid negative, showing sclerosis. To explore the tempero-sphenoidal lobe the skull was opened an inch and a quarter above and behind the external auditory meatus. The dura bulged and was opened; so did the brain, and a trocar was introduced downward, forward and inward for one inch, giving vent to an ounce and a half of pus. Drainage and complete recovery.—*Lancet*.

TREATMENT OF URETHRAL FISTULA.—Lauenstein (Hamburg) has applied the principle of Tait's "flap splitting" operation to urethral fistulae with good results. The opening is separated into two flaps, the urethra forming one and the skin the other, by a circular incision about a quarter of an inch deep. The denuded surfaces are then drawn together by two layers of catgut sutures. The urine is kept from the wound by a catheter à demeure.—*Deutsche Zeitschrift für Chirurgie*.

GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D. AND J. NICHOLAS MITCHELL, M.D.

EXTRAUTERINE PREGNANCY.—Professor Pinard reports twelve cases, where the pregnancy had advanced to the sixth month, the children being dead, with the result of saving eleven of the mothers, and offers the following conclusions as a result of his experience:

1. From the etiological point; if in some cases, previous disease of the genital organs has been noticed, in others no such history has been given.

2. The first accident and functional disturbance has shown itself by the end of the first month.

3. The accidents have consisted of peritoneal phenomena, and functional troubles on the part of the intestines and bladder.

4. The expulsion of a decidua has failed in the majority of cases.

5. Menstruation was suppressed during the extrauterine pregnancy, and did not reappear until two or three months after the death of the fœtus.

6. The attachments of the uterus to the fœtal sack are very variable; if the uterus is oftenest pushed forward it is at times found backward, to one side, or as in one case not at all displaced, but resting in the centre of the pelvis.

7. The fœtus dies generally before its full development, as in only one case was one found of normal weight.

8. The fœtal cyst, though oftenest immobile can be found movable, as seen in my fifth case; it can even present contractions as frequent and strong as the uterus, a fact which I emphasize as I have never seen it stated.

9. The fœtal cyst can be surrounded by convolutions of the intestines passing in front of it, and so adherent that it is impossible to separate them.

10. The fœtal cyst always presents two sacks, one fœtal, the other placental, and capable of separate breaking.

11. Sometimes the fœtal cyst is in two lobes, is strangulated and renders the extraction of the fœtus difficult or impossible, as the seventh case in the series shows.

12. In certain cases on account of attachments to the pelvis, bladder or uterus, it is easier to reach it through the vagina than through the abdomen. According to these conditions, one gives the preference to elytrotomy or to laparotomy.

13. These observations show the danger in always attempting to lift up the cyst, and on the contrary the advantage of a simple turning out of it.

14. They prove that, as soon as a granular membrane is discovered on the internal face of the cyst, one can and should perform an artificial delivery.

15. Cases ten and twelve are good examples of rupture of the cyst at an advanced stage of the pregnancy without the production of hæmorrhage or peritonitis, and of the tolerance of the intestines to contact with a fœtus in the abdominal cavity. They also go to prove that three months after the death of the fœtus, one can proceed without danger to the removal immediately of the placenta.

16. Case six serves to call attention to the grave accidents which can show themselves some days after the death of the fœtus.

17. Finally, all these cases illustrate the great benefit that may be procured by a judicious intervention in cases of extrauterine pregnancy since I have operated twelve cases and cured eleven. The only woman who died was operated in extremis.—*Annales de Gynécologie et d'Obstétrique*, August and September, 1892.

PESSARIES AND UTERINE DISPLACEMENTS—LAWSON TAIT.—He has abandoned the use of pessaries and adopted the following course of treatment with the belief that the potash salts have a specific action on sub-involution of the uterus. Five grains of the chlorate of potash dissolved in a few drops of muriatic acid and given three times a day with the addition of a little ergot at each menstrual period. In eighty-five to ninety per cent. of all uncomplicated cases the uterus diminishes in size, resumes its normal position and the symptoms are relieved. Treatment, as a rule, must be continued for six months.—*Journal of Materia Medica*.

RESECTION OF THE UTERUS FOR CHRONIC SUPPURATION IN PELVIS—TH. LANDAU.—The uterus sinks down in the pelvis like the keystone of an arch and soon closes up any vaginal incision for the purpose of drainage. Péan has advo

cated vaginal extirpation of the uterus to secure drainage but Landau has succeeded by resecting a portion of the uterus toward the abscess. The operation applies to very extensive suppuration deep in the pelvis and almost or quite inaccessible by laparotomy.—*Centralblatt für Gynäkologie*, No. 35, 1892.

OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

GONORRHOEAL CONJUNCTIVITIS.—In the *Geneeskundtjdschrift van ned. Indië*, xxi. Haga reports good results from Burckhardt's plan of treatment. Once every day a solution of salicylic acid is employed as a douche for the eye, 1 to 5 parts to 1000. Every two hours one drop of nitrate of silver solution, 1 to 600, is carefully dropped into the eye. Compresses wet with tepid infusion of chamomile flowers (*anthemis nobilis*), one quart containing fifteen grains each of salicylic and boracic acid, are used constantly.

A SUBSTITUTE FOR THE NASAL DOUCHE.—Dr. Bloebaum no longer uses the nasal douche in removing crusts from the nasal cavity. He simply twists a long and thin roll of cotton on to a knitting needle, introduces it into the nose, and withdraws the needle, leaving the cotton in the nose. A second and third are introduced thus, until the entire cavity is filled. Then one may begin with the opposite side and do likewise. In the course of a quarter of an hour the mucous membrane begins to secrete profusely, and if the cotton is then removed, it will be found that it is saturated with secretions, and the crusts lie on the rolls of cotton, thus leaving a nicely cleansed cavity for the application of the remedies. He never employs any watery solutions, but salves, which are rubbed into the nasal mucous membrane, or powders which are insufflated.—*Lancet Clinic*.

TREATMENT OF VITREOUS OPACITIES BY FLUID EXTRACT OF JABORANDI.—De Schweinitz gives notes of some cases of vitreous opacities treated with jaborandi, as first suggested by Dr. J. A. Spalding (*Arch. of Ophthal.*, April, 1892.) Five cases were thus treated, in every instance with the most satisfactory results. The following case is a type of the rest. A patient, aged 65, with commencing cortical cataract, and slight astigmatism, had $V = 5/7.5$ in both eyes. Vision rather suddenly got worse, so that in one eye it fell to 6/15. The vitreous was found very hazy, with many floating bodies. Locally, eserine sulphate 1/24 grain to the ounce was ordered, and ten drops internally of extract jaborandi three times daily. After twenty-six days the vision in the bad eye had improved to 6/9, and the vitreous had practically cleared. The patient's condition continued satisfactory. De Schweinitz lays stress on the simultaneous local use of eserine, both as a safeguard against rise of tension and to relieve any accommodative asthenopia. Though in some of the cases other drugs as well were used, the author thinks the main credit was due to the jaborandi, which may be used either as fluid extract or as the nitrate of pilocarpin.—*The British Medical Journal*, September 9, 1892.

ANTIPYRINE IN EPISTAXIS.—Dr. E. G. West, of Boston, says that he has yet to find an agent so reliable in epistaxis as antipyrine. It is his custom, when a case of unusual violence occurs, to saturate a pledget of cotton with a solution of antipyrine or with the dry powder and introduce it into the nostril. It has stopped the bleeding in every instance that he has applied it. The patient, by this method, is spared the disagreeable tarry clots formed by the solutions of iron so commonly used for this purpose.—*New York Medical Journal*, Oct. 22, 1892.

MAGGOTS IN THE EAR.—Dr. Dolph (*Indiana Medical Journal*) reports a case where he injected a weak solution of carbolic acid, and in a few minutes over seventy maggots, about one-eighth of an inch in length, crawled out. The patient had been deaf for years in that ear, and always had a slight discharge from it.

The editor refers to *Leidy's Annual* for 1892 for valuable notes on myosis intestinalis, and says that in myosis narium any fixed or volatile oil will promptly destroy all lice, mites and insects.

MONTHLY RETROSPECT OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

CLARENCE BARTLETT, M.D.,

FRANK H. PRITCHARD, M.D., AND E. M. HOWARD, M.D.

TREATMENT OF ASTHMA.—Dr. Schepens de Gaud says the principal remedies are ipecac, sambucus niger, cuprum, lobelia inflata and bryonia.

Indications for Ipecac.—Dyspnœa, accompanied with mucous râle and signs of asphyxia; bronchial cough, with laryngeal strangling and suffocation. Dose, 1x trituration 25 centigrammes in 125 of water; one tablespoonful every half hour.

Sambucus Niger.—Excessive dyspnœa; violet color of the face and more marked signs of asphyxia than in ipecac. Dose, ten drops of the tincture in 125 grammes of water; tablespoonful every half hour.

Cuprum.—Spasmodic dyspnœa, with suffocating cough and constriction of the chest; vomiting, which relieves the patient, is an additional indication for cuprum. There are also cramps and muscular spasms in other parts of the body. Dose, two drops of the sixth solution in 125 grammes of water; tablespoonful every half hour.

Lobelia Inflata.—Dyspnœa, with contraction of larynx and thorax; feebleness and irregularity of the pulse. According to Hughes, gastric complications are also indications for the exhibition of lobelia.

Bryonia.—Bronchitis and pain in the side, increased by respiratory movements. Dose, x., same as cuprum.

Aconite.—When the attack is produced by dry, cold air.—Hughes. Dose, same as sambucus.

Moschus.—Specially indicated in children when there is very marked spasm of the thoracic muscles and larynx. Dose, first decimal trituration by olfaction, or 10 centigrammes in 125 of water; tablespoonful every half hour.

Inhalations of Different Vapors.—Nitrate paper, belladonna, stramonium, and arsenic.

Chronic Asthma.—The four principal remedies are: nux, arsenic, sulphur, and kali hydriod.

Mineral Waters.—The waters of Mount-Dore and Canterets are very efficacious in asthma.—*New Remedies*, October, 1892.

CASE OF MADAROSIS CURED BY PETROLEUM.—Dr. John H. Payne reports a case of Miss N., aged 18 years. Since infancy she had had a total absence of eyelashes, both upper and lower. A close examination under a magnifying glass revealed the presence of a few straggling, very fine hairs, that were scarcely observable to the unaided eye. The edges of the lids had that peculiar, hypertrophied, rounded and glazed appearance, with the loss of the eyelashes, known as madarosis. Her right cornea had a cicatrix from an old ulcer and was very myopic. Her history revealed the fact that she had, during infancy, an eczema behind the auricles that discharged constantly, sometimes a thick pus-like discharge, and again a thin, watery and exoriating discharge. She had at the time of coming under treatment, and had had for many years, a nasal catarrh, characterized by a stuffed feeling at the turbinated bones, with a thick yellow discharge through the nose and mouth; intense itching of the edges of the eyelids and canthi, ameliorated by rubbing. After bathing the face in the morning, there follows a stiff, glazed feeling to the skin, as if covered by a thin layer of albumin, and a dry scurfy formation like dandruff, for which she was accustomed to rub on a little cosmoline with temporary relief. The character of the eczema behind the auricles, and the stiff, glazed feeling to the face induced by bathing, suggested petroleum, which was accordingly prescribed three times

daily. At the end of three months the report was: "Lashes have grown one-eighth of an inch and are quite regular; no itching; nasal catarrh nearly gone." Her progress from this time on was one of steady improvement in catarrhal and skin symptoms, and an entire restoration of the lashes.—*N. E. Medical Gazette*, October, 1892.

THE PHYSIOLOGICAL ACTION AND THERAPEUTIC USES OF BAPTISIA.—The general action of baptisia resembles that of febrile catarrh of an asthenic character and somewhat remittent type. For some years after its introduction as a remedy it was regarded as a specific in the treatment of typhoid, a generalization that was never warranted by the provings, though the remedy is undoubtedly a valuable one in some cases, especially in the first week of the fever. The earliest of the symptoms produced by baptisia are febrile heat and a degree of cerebral excitement. The prover is restless, somewhat excited, cannot rivet his attention on any one topic, complains of a dull stupid feeling in his head, with vertigo and a sense of weakness throughout the body. He feels also a great deal of frontal headache, characterized by a sense of tightness across the forehead, as if the skin were tightly drawn. There is a frequent dull pain in both temples, sometimes in the left, sometimes in the right. This headache is associated with febrile excitement, and is most marked at the beginning of the proving.

During the febrile state the sleep is restless and disturbed by nightmare. The early hours of the night are passed with tolerably sound sleep, but the prover is awakened at 2 A.M., with restlessness, nightmare and excited dreaming. The proving of Douglass is very suggestive of the state of a patient during a low fever. His symptoms also resembled closely those of an intermittent, and should lead to the study of the drug in the treatment of that disease.

The symptoms which represent the action of baptisia on the digestive organs are very characteristic of the kind of febrile disturbance it sets up. The tongue is coated white, with reddish papillæ, then it has a yellowish-brown coating in the centre, the edges being red and shining. On waking in the morning, the tongue feels burned, saliva is rather abundant, somewhat viscid and flat tasting. The tonsils and soft palate look red and congested; the throat feels sore with a sense of tightness, scraping and burning. A raw sensation is noticed as occurring in the pharynx, with a large amount of viscid mucus. Appetite is lost; there is a constant desire for water; some nausea with increased heat. A sense of sinking and emptiness in the stomach. Severe pain is noticed at the cardiac extremity every few minutes. This pain extends from the stomach over the region of the liver, and is sometimes quite sharp and drawing, and at others aching and dull. There is some flatus in the stomach, but much more lower down, producing great abdominal distension, rumbling and borborygmi. Soreness in the abdominal muscles is also felt. Although constipation usually occurs at first, diarrhœa generally follows, the stools being soft, mushy and dark.

The catarrhal-like action of the drug extends to the liver as shown by pain in the right hypochondrium, rendering walking almost impossible.

The urine is dark in color, acid in quality and somewhat diminished in amount.

Another symptom in connection with the febrile condition is a general tired, bruised, sick feeling. The joints feel stiff, the limbs ache, and the projecting parts of the body, such as the ischia, feel extremely sore.

Regarding the preparation from which provings were made, Dr. Pope expresses a regret that the experiments were not made with a decoction, for in a proving made by Dr. Burt by chewing the root, symptoms much more marked than those obtained by the tincture were obtained. He records "constant burning distress in the epigastrium, with severe colicky pains in the umbilical and hypogastric regions, especially in the latter every few seconds, with rumbling of wind in the bowels and desire to vomit, but no nausea; soft stool, drawing pain in the right hip and both calves." He also experienced headache, worse on moving, with frequent sharp pains in the temples. His tongue was yellow, he had a bitter flat taste in the mouth, the tonsils were congested, and all the following forenoon, he had great distress in the bowels and stomach, with desire to vomit and soft mushy stools. These and other symptoms continued for several days, with great exhaustion and finally bleeding from the gums.

Next Dr. Pope considers the claims made for baptisia as a remedy in small-pox, and concludes after a thorough review that the pathogenesis of the remedy warrants us in expecting it to be useful in mitigating the intensity of such adynamia as that which marks the last period of fever in many cases of small-pox.

Then follows a discussion on the merits of baptisia as a specific in the treatment of typhoid. Authors are extensively quoted, and the conclusion reached that baptisia is only adapted to such cases as present the symptoms already enumerated in this review, and in these it will oftentimes work wonderful results.

Baptisia has also been found of service by Dr. Pope in a sore throat of a low type occurring in persons living in houses where the sanitary arrangements are very defective, and offensive smells more or less prevalent in consequence. The throat looks somewhat inflamed, but not much swollen and congested, and there is a raw feeling in it, but there is in addition a feeling of great weakness, of indeed exhaustion out of all proportion to the apparent local weakness.

The dose in which baptisia has generally been given is one, two or three drops of the pure tincture, and perhaps less frequently in drop doses of the 1x dilution.—Dr. A. C. Pope in the *Monthly Homœopathic Review*, October, 1892.

THE CHEST SYMPTOMS OF COCCULUS.—Dr. Dahlke reports the case of a man in the fifties, strongly built, and inclined to corpulency, who presented an anxious suffering appearance. He had been treated, in vain, for several weeks by allopathic physicians. His symptoms were as follows; Pressive pain in the chest, dyspnœa, which was also noticeable on sitting still; cough, worse in the morning, with slight yellowish-expectoration; hoarseness. On examination of the chest, only a few rattling râles were to be heard. The physical examination of the patient revealed nothing in accord with the apparent grave condition of the patient. Two remedies were given in alternation—bryonia and phosphorus. After, the patient called again, but his condition was unchanged. Then he stated that he had a sensation in the chest as if it were hollow, or as if something were lacking. *Cocculus 3c*, *ter die*, was given on account of this symptom. A change took place the same day for the better. In two days this sensation had disappeared, and his dyspnœa markedly decreased, while his general condition had greatly improved. The remedy was continued, and after fourteen days he was discharged cured. The sensation of hollowness was the symptom that led to the selection of *cocculus*. It presents distinctly this symptom, in the provings, in the head and chest especially; there is also dyspnœa and a tense constriction of the chest. *Stannum* also presents a sensation of hollowness in the chest, but, in order that this remedy be indicated there must be an excessive secretion of mucus. Benninghausen places the sensation of emptiness and hollowness under one head. With regard to the stomach, the writer would differentiate between these two. The empty feeling is found under a number of remedies, while the sensation of hollowness, as of a hole, is characteristic of but few. Besides *cocculus*, there might be admitted, *kali carbonicum*, according to Hering's and Kent's statements. A sensation of hollowness in the head is found under *corall. rubr.*, *ignatia*, *opium*, *oxalic acid*, *cocculus*, *sepia*, and *sulphur*. To these may be added, *argent. nitr.*, *carbo.*, *cuprum*, *kali carb.*, and *Stannum*.—*Zeitschrift des Berliner Vereines Homœopatischer Aerzte*, Bd. xi., Hft. iii.

TREATMENT OF ACUTE ARTICULAR RHEUMATISM.—Dr. P. Jousset, at a clinic held at the hospital St. Jacques, Paris, presented several cases of acute articular rheumatism, and considered the treatment of the disease.

China and the Sulphate of Quinine.—These two remedies produce, in the healthy human subject, a painful inflammation of the large and small articulations. These pains may be accompanied by heat and swelling, and are aggravated by the slightest movement or touch. It produces a remittent febrile movement, associated with excessive sweating. Hence, quinine and china are indicated, homœopathically, in the treatment of acute articular rheumatism. Empiricism had long taught that quinine was indicated in the treatment of gout, and before the advent of the salicylates, it was also employed, 2, 3, or 4 grams per diem, in the treatment of acute articular rheumatism. The writer has long been trying to introduce the employment of quinine, in very small doses, in the treatment of articular rheumatism; also, in the acute exacerbations of gout. It is, according to him, indicated by remittance of the febrile movement and pains. These latter are aggravated by the slightest movement or touch. Twenty centigrams to one gram of the first decimal trituration, representing but two to ten centigrams of the crude drug. These doses, though small, give better results than three grams of the crude drug. It cannot be said that it is a specific in rheumatic or gouty arthritis, for there are cases where *bryonia* must intervene. *Aconite* may be necessary where there is a high temperature. Above all, individualize each case. The size of the dose must

vary according to clinical experience. Dr. Petroz, one of the greatest of French homeopaths of the preceding generation, said, "when a remedy is well chosen, it is more preferable to change the dose than the remedy itself." One will, no doubt, be astonished to see quinine prescribed in two diseases so different as gout and rheumatism; but this is due to, and shows how deeply rooted are the ideas of ætiological therapeutics. But, unfortunately, ætiological treatment is based upon hypothesis, upon an immediate knowledge of the cause of the disease, and this cause is usually unknown to us. The homeopathic school, basing itself upon symptoms, obtained, without any hypothetical regard to the cause of the disease, and applying these to the treatment of the disease in question; hence, lays claim, with right, to being the only positive school of positive therapeutics. Yet that does not signify, as some homeopaths have interpreted it that diagnosis prognosis, etc., should be neglected. For, without these, the true nature of the affection will be misunderstood, and the physician be exposed to ridicule, or deceive himself.—*L'Art Medical*, No. 4. 1892.

NATRUM MURIATICUM IN HEADACHE.—Dr. Dahlke was consulted by a man, 49 years of age, for a headache, which would begin every morning at about 8 o'clock, in the middle of the forehead, reaching its maximum between 10 and 11 o'clock, then to decrease in intensity till evening. At the same time he was very irritable. The skin of the forehead was sensitive to pressure, and the bridge of the nose. In the nose, a sensation of dryness. Now and then, he was subject to gouty attacks. He was given *natrum muriaticum* 1x, three pellets, morning and evening. Already the next day the pain was nearly completely relieved, not to return as long as he was under treatment, which was over a month. The remedy was chosen on account of the time of the appearance of the pain. Its setting in early, increasing till noon, and then its gradual decrease. *Spigelia*, as is known, has a headache which follows the sun. *Gelsemium* and *glonoine* also have headaches which have this peculiarity. In these two latter, the intensity of the sun's rays is the cause of the aggravation. *Glonoine* is a great remedy in sun-stroke, and *gelsemium* is indicated in affections coming on after hot, damp weather. *Kali bichromicum* and *verbasum*, also, have headaches with this peculiarity of the course of the pain. But the aggravation of the symptoms, between 10 and 11 in the forenoon, is characteristic of *natrum mur.* alone. It has an intermittent fever, with a chill, at this hour. There is, without regarding the general times of aggravation, as morning, evening, and night, which is so frequently seen in the homeopathic materia medica, as this aggravation from 10 to 11 in the forenoon. Sulphur is the best known example. It is also found under *arg. nitr.*, *arsenic.*, *iodium*, *ipsecac.*, *natrum carb.*, *phosphor.*, *stannum*, *zinc.*, as well as in several others. The sensation of dryness in the nose also called his attention to *natrum mur.*, for this remedy has this feeling in various mucous membranes. The typical headache of this drug requires a dry mouth. *Crotalus* has a headache with a dry mouth and cold feet. *Natrum mur.* has a sensation of dryness in the tongue, although the tongue itself is not dry. The same is true of *arg. nitricum*. *Nux moschata* is indicated in many affections with excessive dryness of the mouth. All the carbon preparations also present this symptom. This same patient suffered from cold hands, not so much now as before, yet still to such an extent that he was obliged to go to bed with gloves on. This also happens to be a *natrum mur.* symptom. It is also a *petroleum* symptom.—*Zeitschrift des Berliner Vereines Homœopathischer Aerzte*, Bd. xi., Hft. iii.

A NEW PROVING OF APIUM VIRUS.—Dr. Lyman Chase gives the following account of the immediate effects of the sting of a honey-bee in the case of his niece, a healthy woman of middle age: The sting was on the back of the neck. In the course of a few minutes the patient was conscious of a pricking and itching sensation in the palms of both hands. The stinging and itching finally increased to such an extent that she hastened to go within doors, when she became conscious of similar sensations in the soles of both feet. In fact, the pricking and itching became general, as if the whole body was in that condition, though the sensations were not quite so unendurable as in the hands and feet. All this occurred within five minutes of receiving the sting. No pain was felt where the bee stung, though afterwards there was considerable swelling around the spot. To keep quiet was impossible; she felt impelled to move about; constantly rubbing her hands in a laughable manner to others; lifting first one foot and then the other. She applied all known remedies, her hands and feet looking as though they had been scalded; obtaining the greatest relief by soaking them in soda-water, and afterwards wrapping them

in bruised plantain leaves. It was about two hours before she began to feel like her former self.—*N. E. Medical Gazette*, October, 1892.

TREATMENT OF PALPITATION AND OTHER NERVOUS TROUBLES OF THE HEART.—Dr. P. Jousset, of Paris, France, finds palpitation of the heart to be a concomitant symptom of hysteria, melancholia, anemia and dyspepsia. It is characterized by a precipitated beating, often very energetic, with or without pain, in the præcordial region. This beating is usually regular. Regular or irregular intermittence is also to be studied, side by side, with nervous palpitation. It is due to dyspepsia, and is to be distinguished from arrhythmia, so frequent in organic heart diseases. In functional disturbance there is a manifest relation between a difficultly digestible meal and the intermittence, and, again, the patient notices when the heart intermits, while in organic heart affections it is unperceived. This latter sign is inconstant though.

Treatment of the Nervous Palpitation.—The principal remedies are: moschus, cactus, coffea, nux moschata, pulsatilla and tabacum.

Moschus is the principal remedy to relieve the patient during the crisis. It is also the best remedy in hysteric palpitation.

Dose and Administration.—A powder containing one and a half grains of the first trituration usually suffices to allay the palpitation, though a second powder may be given a quarter of an hour after. If one is without the first trituration, olfaction of the first decimal dilution will be sufficient.

Coffea is indicated principally in nervous persons. The palpitation is violent, with lancinating pains in the præcordial region. If the urine is passed in abundance, and there is a certain degree of anguish, the drug is the better indicated.

Dose and Administration.—The sixth dilution is the one most frequently employed. During the attack administer a few dry globules, or in a spoonful of water every ten minutes. To prevent a return, administer it morning and evening.

Nux Moschata is very well indicated in hysteric persons, when the attacks are accompanied by a tendency to become ill and faint. The sixth dilution, administered every fifteen minutes, is the dose most frequently employed.

Spigelia.—The symptoms indicating this remedy are, independent of the intermittence of the pulse, a feeling as of trembling in the heart and pains of anguish in the præcordial region. This drug also includes the dyspepsia, with acidity, eructations and nausea, pressure in the stomach. The first six dilutions are used.

Cactus.—This remedy is doubly acting, it influencing both the palpitation and the dyspepsia. There is slow digestion, enormous sense of heaviness of the stomach, oppression, regurgitation of food eight to ten hours after eating, and arterial pulsation. The cardiac symptoms are: intermittence, with anguish, and præcordial pain. The dosage is the same as in spigelia.

China.—Dyspepsia and intermittence of the heart are the symptoms constantly produced by china. Clinical experience has confirmed the happy action of this drug upon the intermittence of dyspepsia. It is especially indicated in cases where there is a sensation of great fullness even after a slight meal; great flatulence, and still the appetite is preserved. Use from the sixth to the twelfth dilution.

Sepia.—The pathogenesis of this drug presents a perfect image of cardiac troubles and dyspepsia. The dyspepsia is very exquisite. There is burning in the stomach, regurgitation, nausea, epigastric pulsation, intermittence of the heart, after a meal. Suspension of the heart-beat is associated with a feeling of terrible anguish. Colic and repeated stools complete the clinical indications. Employ from the sixth to the twelfth trituration.

Carbo Vegetabilis.—The pathogenesis of this drug is almost that of the preceding one. The dyspepsia is accompanied by colic and tympanitis, with intermittence of the pulse, especially immediately after eating and on lying down. Administered at the moment of the appearance of the symptoms, it calms them at once. The third trituration is ordinarily used by the writer.

Strophanthus.—This remedy is one of the principal means of combatting the arrhythmia of arterio sclerosis. It is to be thought of when the intermittence becomes, to a certain degree, permanent, and where there is possibly a certain amount of arteritis present. The usual dose is from five to fifteen drops of the mother tincture per diem.

Treatment of the Syncope.—This condition is due to a lack of afflux of blood to the brain. Hence, place the patient into a horizontal position, throw water upon his body, especially with a spray. Wine, alcohol and opium, in a moderate dose, prevent its return in driving a supply of blood to this organ.

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